HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
APRIL 25, 2018
APPLICATION SUMMARY

NAME OF PROJECT:	Regional Med Extended Care Hospital LLC, d/b/a Regional One Health Extended Care Hospital
PROJECT NUMBER:	CN1801-003
ADDRESS:	890 Madison Avenue, 4th Floor Memphis, TN (Shelby County), TN 38103
LEGAL OWNER:	Shelby County Health Care Corporation 877 Jefferson Avenue Memphis (Shelby County), TN 38103
OPERATING ENTITY:	NA
CONTACT PERSON:	E. Graham Baker, Jr., Attorney (615) 370-3380
DATE FILED:	January 11, 2018
PROJECT COST:	$8,729,910
FINANCING:	Combination of Lease and Cash Reserves
PURPOSE FOR FILING:	Addition of 24 long term acute care hospital (LTCH) beds to its current 24 bed (plus 6 CON approved but not yet implemented beds) LTCH

DESCRIPTION:

Regional Med Extended Care Hospital LLC, d/b/a Regional One Health Extended Care Hospital is seeking approval for the addition of 24 long-term acute care beds to its current 24 bed (plus 6 CON approved but not yet implemented beds) LTCH located at 890 Madison Avenue Memphis, (Shelby County), TN 38103. No other health services will be initiated or discontinued. If approved, the projected initiation of service is April 2021.

SPECIFIC CRITERIA AND STANDARDS REVIEW:

LONG TERM CARE HOSPITAL BEDS

A. Need

1. The need for long term care hospital (LTCH) beds shall be determined by applying the guidelines of (0.5) beds per 10,000 population in the service area of the proposal.

The bed need was calculated by the Tennessee Department of Health, Division for Policy, Planning and Assessment. The 2020 bed need for the proposed Community Services Agency (CSA) service area is 49 beds. There are currently 93 licensed beds in the service area plus 6 approved yet unimplemented beds. According to the formula, in 2020 there is a projected surplus of 50 LTCH beds in the proposed service area.

	Population		0.5 LTACH bed X (10,000 population)		Current licensed beds	Current CON approved but unimplemented beds	Net Need	
	2018	2020	2018	2020	2018	2018	2018	2020
Shelby County (Proposed Service Area)	970,212	981,022	48 beds	49 beds	93 beds	6 beds	(51) bed surplus	(50) bed surplus

Source: CN1801-003

It appears that this criterion is not met.

Note to Agency members: The applicant points out that only 53% of its patients reside in Shelby County. The balance of patients includes 37% from out of state, mainly Mississippi and Arkansas, and another 10% from other Tennessee counties.

2. If the project is a bed addition, existing long term care hospital beds must have a minimum average occupancy of 85%.

The four long term care hospitals in the proposed service area representing 129 beds averaged a 72.5% occupancy rate in 2016. This takes into account that 36 bed Methodist Extended Care Hospital only reported for the period 1/1/2016 – 6/30/2016. This facility has since closed.

It appears that this criterion is not met.

3. The population shall be the current year's population, projected two years forward.

   The Tennessee Department of Health, Division of Policy, Planning and Assessment projected the current total population of the Tennessee portion of the service area two years forward (981,022 residents in CY2020).

4. The primary service area cannot be smaller than the applicant's Community Service Area (CSA). If LTCH beds are proposed within an existing hospital, CSAs served by the existing facility can be included along with consideration for populations in adjacent states when the applicant provides documentation (such as admission sources from the Joint Annual Report).

   This is an existing LTCH located in the Shelby County Community Services (CSA) Region. The applicant has also included data from bordering states Mississippi and Arkansas.

   It appears that this criterion is met.

5. Long-term care hospitals should have a minimum size of 20 beds.

   The applicant currently is licensed for 24 beds and has 6 CON approved yet unimplemented beds.

   Since the applicant's LTCH is an existing facility, this criterion is not applicable.

B. Economic Feasibility

1. The payer costs of a long-term hospital should demonstrate a substantial saving, or the services should provide additional benefit to the patient over the payer cost or over the provision of short-term general acute care alternatives, treating a similar patient mix of acuity.

   LTCH services is a category created by CMS that provides substantial savings over traditional acute care services for long term acute care patients. In Supplemental #1, the applicant notes the average inpatient cost per day at Regional One is $3,137. The total operating expenses per day for Regional One Health Extended Care Hospital is $1,730 per day. With a daily differential of

$1,407 multiplied by the length of stay as reported on the most recently filed cost report of 33.75 days for LTCH patients, Regional One should realize a cost savings of $47,486 per Medicare patient by transferring the patient to LTCH instead of retaining the patient in an acute care hospital bed.

It appears that this criterion is met.

2. The payer costs should be such that the facility will be financially accessible to a wide range of payers as well as to adolescent and adult patients of all ages.

The applicant's historical payor mix has been approximately 70% Medicare, 6% TennCare, 18% Commercial, 6% Workers' Compensation, and 1% Self-Pay.

The applicant's historical age mix of patients is reported as Age 65+, 49%; Age 45-64, 20.9%; Age 18-44, 28.6%, and Age 0-17, 1.5%.

The applicant's projected payor mix in Year One is 66.8% Medicare, 10.1% Medicaid, and Commercial 19.7%.

It appears that this criterion is met.

3. Provisions will be made so that a minimum of 5% of the patient population using long-term acute care beds will be charity or indigent care.

The applicant did not report any charity care in the most recent historical year. The applicant provides a discussion on page 11 of Supplemental #1 essentially suggesting that this criterion is no longer reasonable and should be considered for revision.

It appears that this criterion has not been met.

C. Orderly Development

1. Services offered by the long term care hospital must be appropriate for medically complex patients who require daily physician intervention, 24 hours access per day of professional nursing (requiring approximately 6-8 hours per patient day of nursing and therapeutic services), and on-site support and access to appropriate multi-specialty medical consultants.

Regional One Health Extended Care Hospital is an existing LTCH provider that is already providing this level of service. The applicant is projecting 9.48 RN and .4 therapy hours per patient care day.

It appears that this criterion is met.

Patient services should be available as needed for the most appropriate provision of care. These services should include restorative inpatient medical care, hyperalimentation, care of ventilator dependent patients, long term antibiotic therapy, long-term pain control, terminal AIDS care, and management of infectious and pulmonary diseases.

Regional One Extended Care Hospital is an existing LTCH provider that is already providing these services.

It appears that this criterion is met.

Also, to avoid unnecessary duplication, the project should not include services such as obstetrics, advanced emergency care, and other services which are not operationally pertinent to long term care hospitals.

Regional One Extended Care Hospital is an LTCH that provides appropriate long term acute services to its patients.

It appears that this criterion is met.

2. The applicant should provide assurance that the facility's patient mix will exhibit an annual average aggregate length of stay greater than 25 days as calculated by the Health Care Finance Administration (HCFA), and will seek licensure only as a hospital.

   The average length of stay at the applicant facility was 36.53 days in 2016.

   It appears that this criterion is met.

3. The applicant should provide assurance that the projected caseload will require no more than three (3) hours per day of rehabilitation.

   The applicant indicates that for the most recent year available, rehabilitation has been at 0.4 hours per day.

   It appears that this criterion is met.

4. Because of the very limited statewide need for long term hospital beds, and their high overall acuity of care, these beds should be allocated only to community service areas and be either inside or in close proximity to tertiary referral hospitals, to enhance physical accessibility to the largest concentration of services, patients, and medical specialists.

   The applicant is located inside a tertiary facility and is in the same county as several other tertiary care facilities.

   It appears that this criterion is met.

5. In order to insure that the beds and the facility will be used for the purpose certified, any certificate of need for a long term care hospital should he conditioned on the institution being certified by the Health Care Financing Administration as a long term care hospital, and qualifying as PPS-exempt under applicable federal guidelines. If such certification is received prior to the expiration date of the certificate of need, as provided in Tennessee Code Annotated (TCA), Section 68-11-108(c), the certificate of need shall expire, and become null and void.

   The applicant agreed in the application to abide by the conditions and terms listed above.

STAFF SUMMARY

Note to Agency members: This staff summary is a synopsis of the original application and supplemental responses submitted by the applicant. Any HSDA Staff comments will be presented as a "Note to Agency members" in bold italic.

Application Synopsis

Regional One Health Extended Care Hospital is a 24 bed licensed Long-Term Care Hospital (LTCH) (with 6 additional CON-approved but unimplemented beds) licensed by the Department of Health, located in Memphis (Shelby County), TN. The 24 private-bed LTCH is currently located on the 4th Floor of Regional One Health's Turner Building. The 6 additional CON approved beds will be located on the 2nd floor of the Turner Building. The proposed 24 beds will be located on the 3rd floor of the Turner Building. If approved, the total licensed bed complement of Regional One Health Extended Care Hospital will increase from 24 to 54. All LTCH beds will be in private rooms.

Regional One Health Extended Care Hospital is a hospital within a hospital, which is defined in federal regulations at 42 CFR 412.22(e) as a hospital which occupies space in a building also used by another hospital or on the campus of another hospital.

The LTCH's host hospital, Regional One Health, is a 631 bed licensed hospital (staffed at 331 beds in 2016) with a Level One Trauma Center and Regional Burn Center.

Note to Agency members: LTCHs provide extended medical and rehabilitative care to individuals with clinically complex medical problems, such as multiple acute or chronic conditions, that need hospital-level care for relatively extended periods. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average inpatient length of stay greater than 25 days. The Bipartisan Budget Act of 2013 reinstated the moratorium of the establishment of an LTCH, increasing existing LTCHs' number of licensed beds, or the establishment of a satellite by an existing LTCH for the period of January 1, 2015 to September 30, 2017. The moratorium expired on September 30, 2017.

Facility Information

- Regional One Hospital and Regional One Health Extended Care Hospital are separately licensed and both owned by Shelby County Health Care Corporation. The LTCH beds in the Turner Building will be distinctly separated from Regional One Health acute beds per Licensure standards.

  The following table identifies the current location of licensed beds in the Turner Building.

Building	Floor #	Type of Unit	Licensed Beds	Staffed Beds
Turner	4	LTCH	24	24
	3	Rehab	24	24
	2	Rehab	6	0
	G	Burn Unit	14	14
	B	Detention Unit	10	10
Total Beds			**78**	**72**

- Historically 21 of the 24 LTCH beds were staffed on the 4th floor. The applicant indicated in supplemental #1 that due to increased demand all 24 beds are now staffed.

  The following table identifies the proposed location of licensed beds in the Turner Building.

Building	Floor #	Type of Unit	Licensed Beds	Staffed Beds
Turner	4	LTCH	24	24
	3	LTCH	24	24
	2	LTCH	6	6
	G	Burn Unit	14	14
	B	Detention Unit	10	10
Total Beds			**78**	**78**

- In Supplemental #1 the applicant indicated that rehab beds will be relocated; however the location has not yet been determined.

Ownership

The ownership structure for the applicant is as follows:

- The applicant, Regional One Extended Care Hospital, is owned by Shelby County Health Care Corporation.

NEED

Project Need

The applicant provides the following justification in the application:

- The addition of 24 beds, within a physical space that provides for more efficient coordination for the hospital and patients, will permit greater access for care for this highly acute patient population with a need for an extended, acute care stay.
- Since Regional One Health serves as a Level One Trauma Center and Regional Burn Center, there is a need for long term acute care services within its post-acute complement. Patients with extended care needs have a need for long-term acute care services (related to ventilator management and weaning) within its post-acute complement.
- Select Specialty Hospital, another LTCH in Memphis, recently (July 10, 2017) voluntarily surrendered its approved CON for an additional 24 beds.
- Methodist Hospital has closed its 36 bed LTCH recently and now refers their long-term care patients to the applicant.

Note to Agency members: In 2015 Methodist Extended Care Hospital's 36 licensed beds located at 225 South Claybrook, Memphis (Shelby County) was staffed at 32 beds. The 2015 licensed occupancy was 87.4% and staffed occupancy was 98.3%. The 2016 Joint Annual Report indicates Methodist Extended Care Hospital reporting period ended June 30, 2016. The Department of Health's facility licensure website identifies this hospital's facility status as closed.

Service Area Demographics
Primary Service Area
Regional One Health's declared primary service area is Shelby County.

Total Population

- The total population of the primary service area is estimated at 970,212 residents in calendar year (CY) 2018 increasing by approximately 1.1% to 981,022 residents in CY 2020.
- The total population of the state of Tennessee is expected to grow 2.2% during the same timeframe.

65+ Population

- The total 65+ age population is estimated at 125,389 residents in CY 2018 increasing approximately 7.9% to 135,234 residents in 2020. The 65+ age population in the state of Tennessee overall is expected to increase 7.8% during the same timeframe.
- The Age 65+ population in the primary service area is projected to equal 13.8% of the total population in 2020. This compares to 17.8% for the State of Tennessee overall.

TennCare Population

- The latest 2018 percentage of the primary service area population enrolled in the TennCare program is approximately 25.5%, as compared to the statewide enrollment proportion of 20.8%.

Source: The University of Tennessee Center for Business and Economic Research Population Projection Data Files, Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics.

Service Area Historical Utilization
LTCH Utilization Trends
The reported LTCH Joint Annual Report utilization data for the latest three available years is contained in the following table:

LTCH Shelby County UtilizationTrends-2014-2016

Facility	Licensed Beds	2014 Pt Days	2015 Pt Days	2016 Pt Days	'14- '16 % change	2014 % Occupancy	2015 % Occupancy	2016 % Occupancy
Baptist	30	8,499	8,354	7,041	-17.1%	77.2%	76.3%	64.3%
Methodist	36	11,752	11,485	4,808*	-18.2%	89.4%	87.4%	73.2%*
Select Specialty	39	13,724	13,388	10,311	-24.9%	96.4%	94.0%	72.4%
**Regional One	24	1,711	6,854	7,160	+318%	19.5%	78.2%	81.7%
Total	**129**	**35,686**	**40,081**	**29,320**	**-17.8%**	**75.7%**	**85.1%**	**72.5%**

*Source: LTCH JARs, 2014-2016 *Methodist 2016 data based on 6 month period 1-1-2016 to 6-30-2016*
***Regional One Extended Care opened in 2014.*

- The overall utilization of LTCHs in the service area decreased 17.8% from 35,686 patient days in 2014 to 29,320 days in 2016. The only LTCH that experienced an increase in patient days was Regional One.
- In 2016 the licensed occupancy of LTCHs ranged from 64.3% at Baptist Memorial Restorative Care Hospital (Shelby County County) to 81.7% at Regional One Extended Care Hospital (Shelby County County).

The following is a table providing the LTCH utilization trends of admissions and average length of stay from 2014 to 2016.

Shelby County
LTCH Admissions and Average Length of Stays (LOS)-2014-2016

Facility	Licensed Beds	2014 Admissions	2015 Admissions	2016 Admissions	2014 Average LOS	2015 Average LOS	2016 Average LOS
Baptist	30	259	250	214	32.6	33.4	32.9
Methodist	36	435	424	172*	27.0	27.1	28.0*
Select Specialty	39	422	405	344	32.6	33.1	30.0
**Regional One	24	63	181	196	27.2	37.9	36.5
Total	129	1,179	1,120	926	30.2	35.8	31.7

Source: LTACH JARs, 2014-2016
**Methodist 2016 data based on 6 month period 1-1-2016 to 6-30-20*
***Regional One Extended Care opened in 2014.*

- Shelby County LTCH admissions declined 21.5% from 1,179 in 2014 to 926 in 2016. The only LTCH that experienced an increase in admissions was Regional One.

Applicant Historical and Projected Utilization
The following are tables reflecting Regional One Health Extended Care Hospital's LTCH historical and projected inpatient utilization.

Regional One Health Extended Care Hospital LTCH
Historical and Projected Utilization

Variable	2014	2015	2016	% Change '14-'16	Year 1	Year 2
Licensed Beds	24	24	24		54	54
Admissions	*63	181	196	+211%	444	444
Patient Days	*1,711	6,854	7,160	+318%	16,805	16,805
Average LOS	27.2	37.9	36.5		38	38
% Licensed Occupancy	19.5%	78.2%	81.7%		84.6%	84.6%

Source: CN1801-003
**The applicant facility began operation in 2014*

- Regional One Health Extended Care Hospital's patient days increased 318% from 1,711 in 2014 to 7,160 in 2016.
- The applicant projects a 135.7% increase in utilization from 7,160 patient days on 24 beds in 2016, to 16,805 in Year One on 54 licensed beds.
- The applicant projects a 126.5% increase in admissions from 196 (24 beds) in 2016 to 444 (54 beds) in Year 1.
- The applicant projects the average length of stay (LOS) per patient will increase from 36.5 days in 2016 to 38 days in Year One.

Note to Agency members: The applicant was asked to discuss in detail the assumptions used to project over 125% increase in admissions from 2016 and the first year after project completion. The applicant refers to stricter medical acuity criteria established by CMS in order for LTCHs to receive 100% reimbursement. The applicant expects to be in a good position regarding these criteria since the host hospital (Regional One Health) is a Level I trauma center and has a Burn Center. The applicant notes that its LTCH is the only one in the primary service area that has experienced utilization growth between 2014 and 2016. For more details see page 4 of Supplemental #2.

ECONOMIC FEASIBILITY

Project Cost

Major costs are:

- Fair Market Value of Leased Space- $6,210,000, or 71% of cost.
- Fair Market Value of Leased Fixed Equipment- $1,230,000, or 14.2% of the total cost.
- For other details on Project Cost, see the Project Cost Chart on page 28R in the original application.
- The proposed project does not involve any renovation or construction cost.

Financing

The majority of project costs represent the Fair Market Value of the leases that represents $7,440,000. The remaining amount of $1,240,000 in the Project Costs Chart will be paid with cash reserves of the applicant.

A January 11, 2018 letter from Mark A. Kelley, Regional One Health's Administrator and CEO, confirms that Regional One Health has sufficient cash reserves on hand to finance the proposed project.

Shelby County Health Care Corporation's audited financial statements for the period ending June 30, 2016 indicates $16,710,050 in cash and cash equivalents, total current assets of $214,067,253, total current liabilities of $58,980,586, and a current ratio of 3.63:1.

Note to Agency members: Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

- The applicant projects a net operating margin ratio for the total facility of 12.2% in Year 1 and 10.5% in Year 2.

Note to Agency Members: The net operating margin demonstrates how much revenue is left over after all the variable or operating costs have been paid.

- Shelby County Health Care Corporation's capitalization ratio was 14.68% in 2016.

Note to Agency Members: The capitalization ratio measures the proportion of debt financing in a business's permanent financing mix.

Historical Data Chart

- According to the Historical Data Chart, Regional One Health experienced positive Free Cash Flow (Net Balance + Depreciation) for the three most recent years reported: 3,335,216 for 2015; $642,381 for 2016; and $634,500 for 2017.

Projected Data Chart
54 LTCH Beds

The applicant projects $137,801,340 in total gross revenue on 16,805 patient days during Year One and Year 2 (approximately $8,200 per day). The Projected Data Chart reflects the following:

- Free Cash Flow (Net Balance + Depreciation) for the applicant is projected to be $8,352,258 in Year One decreasing to $7,915,309 in Year Two.
- Net operating revenue after contractual adjustments is expected to reach $30,260,799 or approximately 22% of total gross revenue in Year Two.
- Charity care totals $541,138 in Year Two, equaling 66 total charity patient days.

Note to Agency members: In FY 2005, a special payment adjustment policy, commonly called the 25 percent threshold rule, was finalized. As defined by Code of Federal Regulations (CFR) at 42 CFR 412.534, it applied only to discharges from LTCH

hospitals within hospitals (HwH) or satellites of an LTCH co-located with a host hospital or on the campus (any facility within 250 yards of the hospital) that had been admitted from the co-located hospital. Payments were adjusted for certain discharges for cost reporting periods in which more than 25 percent of the LTCH HwH's or LTCH satellite's discharges were admitted from its co-located host hospital. Specifically, after the 25 percent payment threshold was crossed, the net payment amount for the discharges occurring beyond the threshold was based on the lesser of a payment based on the MS-LTC-DRGs or an amount equivalent to what Medicare would have otherwise paid under the inpatient prospective payment system (IPPS)

The implementation of the 25-percent rule has been delayed due to a regulatory moratorium due to expire September 30 2018. The applicant in Supplemental #1 acknowledged that historically admissions from the host hospital has been in the 50-55% range. The applicant states that it is undetermined whether or not the regulatory moratorium on the 25 percent threshold rule will be lifted on October 1, 2018. It should be noted that the applicant does not assume the 25% threshold rule will be in effect in the calculations pertaining to the Projected Data Charts.

For more details on the applicant's response to the 25% rule see pages 1-2 of Supplemental #1 and page 1 of Supplemental #2.

Project Only (24 beds)

The applicant projects $59,368,000 in total gross revenue on 7,240 patient days during Year One and Year Two (approximately $8,200 per day). The Projected Data Chart reflects the following:

- Free Cash Flow (Net Balance + Depreciation) for the applicant will equal $6,243,000 in Year One decreasing to $6,108,340 in Year Two.
- Net operating revenue after contractual adjustments is expected to reach $13,037,080 or approximately 22% of total gross revenue in Year Two.
- Charity care totals $151,352 in Year Two, equaling 18.46 total charity patient days.

Charges

In Year One of the proposed project, the average charges are as follows:

- The proposed average gross charge is $8,197/day in Year 1.
- The average deduction is $6,400/day, producing an average net charge of $1,797/day.

Payor Mix

Payor Source, Year 1-Total Facility

Payor Source	Gross Revenue	As a % of Total
Medicare	$94,291,123	66.8%
Tenncare/Medicaid	$14,209,583	10.1%
Commercial	$27,901,588	19.7%
Self-Pay	$269,303	0.2%
Charity Care	$701,615	0.5%
Other (other gov't, worker's comp)	$3,756,800	2.7%
Total Gross Revenue	**$141,130,012**	**100%**

Source: CN1708--025

- Medicare-Gross Operating Income will equal $94,291,123 in Year One representing 66.8% of total gross operating income.
- TennCare/Medicaid-Gross Operating Income will equal $14,209,583 in Year One representing 10.1% of total gross operating income.
- The applicant contracts with all four TennCare managed care organizations.

PROVIDE HEALTHCARE THAT MEETS APPROPRIATE QUALITY STANDARDS

Licensure

- Regional One Health Extended Care Hospital is licensed by the Department of Health.
- A copy of the latest Department of Health licensure survey dated 1/11/2017 is located in Attachment B. Orderly Development.D2.
- A letter dated April 5, 2017 from the Department of Health indicates a correction action plan was accepted as a result of the 1/11/2017 licensure survey and that Regional One Health Extended Care Hospital is in substantial compliance with all participation requirements as of February 25, 2017.

Certification

- The applicant is certified by Medicare and Medicaid/TennCare.

Accreditation

- Regional One Health Extended Care Hospital is not accredited by any nationally recognized accrediting organization. The applicant stated that accreditation is not required for the operation of a LTCH. If CMS were to require accreditation in the future, the applicant will comply.

Other Quality Standards

- In the first supplemental response the applicant commits to obtaining and/or maintaining the following:
  - Staffing levels comparable to the staffing chart presented in the CON application
  - Licenses in good standing
  - TennCare/Medicare certifications
  - Three years compliance with federal and state regulations
  - Has not been decertified in last three years
  - Self-assessment and external peer assessment processes
  - Data reporting, quality improvement, and outcome/process monitoring systems

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

Agreements

- The applicant has a transfer agreement with Regional One Health.
- The physician group agreement is with Sleep and Pulmonary Specialist, PLLC.

Impact on Existing Providers

- Since 60 LTCH beds were voluntarily surrendered within the last year in Shelby County, the decrease in bed availability has increased the bed need for patients who need LTCH services. The addition of these requested beds will have little impact on existing providers in the area.

Staffing

The applicant's proposed Year One staffing includes the following:

Position	Existing FTEs	Projected FTEs Year One
RNs	53.3	91.3
CNA	10.1	19.9
Patient Care Extern	0.5	0.9
Liaison Nurse	2.0	4.0
Lead Respiratory Therapist	1.0	2.2
Occupational Therapist	0.8	1.6
Physical Therapist	0.9	1.8
Speech Pathologist	1.0	1.9
Patient Care Coordinator	3.5	7.4
Respiratory Therapist/RRT	10.2	20.1
Medical Assistant	2.0	3.9
Physical Therapy Assistant	1.1	2.2
Respiratory Therapy Tech/Cert	1.0	2.0
Patent Serv Clerk	5.5	11.1
Total Direct Care	93.8	172.3
Other-Non Direct Care	8.1	10.0
Total	**101.9**	**182.3**

Source: CN1801-003

Should the Agency vote to approve this project, the CON would expire in three years.

Corporate documentation and facility lease information are on file at the Agency office and will be available at the Agency meeting.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

There are no other Letters of Intent or pending applications for this applicant.

Regional One Health has financial interests in this project and the following:

Denied Applications

Baptist Memorial Hospital, CN1705-018D, was denied at the August 23, 2017 Agency meeting for the establishment of a full service, 24 hour per day/7 day per week satellite emergency department to be located at an unnamed street address north of the intersection of Interstate 40 and Airline Road on the eastside, in Arlington (Shelby County). The proposed facility was planned to operate as a satellite emergency department of Baptist Memorial Hospital located at 6019 Walnut Grove Road in Memphis (Shelby County) and have 8 treatment rooms and provide emergency diagnostic and treatment services. The applicant is owned by Baptist Memorial Health Care Corporation. The project was planned to be developed, operationalized, and marketed through a joint operating agreement between Baptist Memorial Hospital and Regional One Health. The estimated project cost was projected to be **$10,016,611.** *Reason for Denial: The application failed to meet the statutory criteria.*

Baptist Memorial Hospital, CN1701-005D, was denied at the April 26, 2017 Agency meeting for the establishment of a full service, 24 hour per day/7 day per week satellite emergency department to be located at an unnamed street address north of the intersection of Interstate 40 and Airline Road on the eastside, in Arlington (Shelby County). The proposed facility was planned to operate as a satellite emergency department of Baptist Memorial Hospital located at 6019 Walnut Grove Road in Memphis (Shelby County) and have 10 treatment rooms and provide emergency diagnostic and treatment services. The applicant is owned by Baptist Memorial Health Care Corporation. The project was planned to be developed, operationalized, and marketed through a joint operating agreement between Baptist Memorial Hospital and Regional One Health. The estimated project cost was projected to be **$9,963,779.** *Reason for Denial: The application failed to meet the statutory criteria.*

Baptist Memorial Hospital Satellite ED Memphis, CN1508-036D, was denied at the November 18, 2015 Agency meeting. The application was for the establishment of a full service, 24 hour per day/7 day per week satellite emergency department to be located at an unnamed street address at 655 Quince Road in Memphis (Shelby County), Tennessee 38119. The proposed facility will be operated as a satellite emergency department of Baptist Memorial Hospital located at 6019 Walnut Grove Road in Memphis and will have 12 treatment rooms and will provide emergency diagnostic and treatment services. The project did not contain major medical equipment, initiate or discontinue any other health service or affect the hospital's licensed bed complement. The project was planned to be developed, operationalized, and marketed through a joint operating agreement between Baptist Memorial Hospital and Regional One Health. The estimated project cost was projected to be **$18,457,700.** *Reason for Denial: The application failed to meet the need or orderly development of health care.*

Baptist Memorial Hospital Satellite ED Lakeland, CN1508-037D, was denied at the February 24, 2016 Agency meeting. The application was for the establishment of a full service, 24 hour per day/7 day per week satellite emergency department to be located at an unnamed street address near the intersection of Highway 64 and Canada Road in Lakeland (Shelby County), Tennessee 38002. The proposed facility was planned to be operated as a satellite emergency department of Baptist Memorial Hospital located at 6019 Walnut Grove Road in Memphis and will have 10 treatment rooms and will provide emergency diagnostic and treatment services. The project did not contain major medical equipment, initiate or discontinue any other health service or affect the hospital's licensed bed complement. The project was planned to be developed, operationalized, and marketed through a joint operating agreement between Baptist Memorial Hospital and Regional One Health. The estimated project cost is **$18,718,029.** *Reason for Denial: The application failed to meet the statutory criteria.*

Outstanding Certificates of Need

Regional MED Extended Care Hospital, LLC dba Regional One Health Extended Care Hospital, CN1708-025A, has an outstanding Certificate of Need that will expire on February 1, 2021. The project was approved at the December 13, 2017 Agency meeting for the addition of six (6) long-term acute care beds to its current twenty-four (24) bed LTCH located at 890 Madison Avenue Memphis, (Shelby County), TN 38103. **The total estimated project cost is $2,215,000.** *Project Status:* **This project was recently approved.**

CERTIFICATE OF NEED INFORMATION FOR OTHER FACILITIES IN THE SERVICE AREA:

There are no other Letters of Intent, denied or pending applications, or Outstanding Certificates of Need for other health care organizations in the service area proposing this type of service.

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, HEALTH CARE THAT MEETS APPROPRIATE QUALITY STANDARDS, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

MAF
(04/05/2018)

LETTER OF INTENT

State of Tennessee 20
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Commercial Appeal which is a newspaper of general circulation in Shelby County, Tennessee, on or before January 10, 2018, for one day.

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This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Regional MED Extended Care Hospital, LLC, d/b/a Regional One Health Extended Care Hospital ("Applicant"), 890 Madison Avenue, 4th Floor, Memphis (Shelby County), Tennessee 38103, a licensed twenty-four (24) bed hospital (with six [6] additional beds approved in December, 2017) providing Long Term Acute Care Hospital ("LTACH") services, owned by Shelby County Health Care Corporation, with the Applicant having an ownership type of Limited Liability Company and the owner having an ownership type of corporation, intends to file a Certificate of Need application for the addition of twenty-four (24) hospital beds limited to LTACH services. The requested twenty-four (24) additional beds will be housed on the 3rd floor of the existing building, and will be licensed by the Tennessee Department of Health as hospital beds. There is no major medical equipment involved with this project. No other health services will be initiated or discontinued. The estimated project cost is anticipated to be approximately $9,000,000.00.

The anticipated date of filing the application is: January 12, 2018.

The contact person for this project is E. Graham Baker, Jr., Attorney, who may be reached at Anderson & Baker, 2021 Richard Jones Road, Suite 120, Nashville, TN 37215, 615/370-3380.

E. Graham Baker, Jr. (Signature) 01/10/2018 (Date) graham@grahambaker.net (E-mail Address)

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

==========

ORIGINAL APPLICATION

Regional Med Extended Care Hospital, LLC,
dba
Regional One Health Extended Care Hospital

(COPY)

CN1801-003

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution

Regional Med Extended Care Hospital, LLC, dba Regional One Health Extended Care Hospital
Name

890 Madison Avenue, 4th Floor — Street or Route
Shelby — County

Memphis — City
TN — State
38103 — Zip Code

Website address: https://www.regionalonehealth.org/extended-care-hospital/

*Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the Publication of Intent.*

2. Contact Person Available for Responses to Questions

E. Graham Baker, Jr. — Name
Attorney — Title

Anderson and Baker — Company Name
graham@grahambaker.net — Email address

2120 Richard Jones Road — Street or Route
Nashville — City
TN — State
37215 — Zip Code

Attorney — Association with Owner
615-370-3380 — Phone Number
615-221-0080 — Fax Number

NOTE: ***Section A*** is intended to give the applicant an opportunity to describe the project. ***Section B*** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, Contribution to the Orderly Development of Health Care, and Quality Measures.

Please answer all questions on ***8½" X 11" white paper, clearly typed and spaced, single or double-sided, in order and sequentially numbered. In answering, please type the question and the response.*** All questions must be answered. If an item does not apply, please indicate *"N/A" (not applicable).* ***Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed signed and notarized affidavit.***

3. SECTION A: EXECUTIVE SUMMARY24

A. Overview

Please provide an overview not to exceed three pages in total explaining each numbered point.

1) Description – Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant;

Response: This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that Regional MED Extended Care Hospital, LLC, d/b/a Regional One Health Extended Care Hospital ("Applicant"), 890 Madison Avenue, 4th Floor, Memphis (Shelby County), Tennessee 38103, a licensed twenty-four (24) bed hospital (with six [6] additional beds approved in December, 2017) providing Long Term Acute Care Hospital ("LTACH") services, owned by Shelby County Health Care Corporation, with the Applicant having an ownership type of Limited Liability Company and the owner having an ownership type of corporation, intends to file a Certificate of Need application for the addition of twenty-four (24) hospital beds limited to LTACH services. The requested twenty-four (24) additional beds will be housed on the 3rd floor of the existing building, and will be licensed by the Tennessee Department of Health as hospital beds. There is no major medical equipment involved with this project. No other health services will be initiated or discontinued. The estimated project cost is anticipated to be approximately $9,000,000.00.

The contact person for this project is E. Graham Baker, Jr., Attorney, who may be reached at Anderson & Baker, 2021 Richard Jones Road, Suite 120, Nashville, TN 37215, 615/370-3380.

The Applicant has one outstanding Certificate of Need application: to add six (6) LTACH beds. However, neither the Applicant nor its owner have any other outstanding Certificate of Need applications that are approved but not yet in service.

The Applicant is approved to add six (6) LTACH beds on the 2nd floor, plus this project is to add twenty-four (24) beds on the 3rd floor. The Applicant has discussed these projects with Licensure, and both projects meet licensure standards.

The 4th floor is a discrete unit attached to but separated from the main hospital by corridors and locked doors, and both the 24 beds on the 3rd floor and the 6 beds on the 2nd floor will be likewise separated from other services on the 2nd floor.

There currently exists the CMS LTACH 25 percent threshold rule. For cost reporting periods beginning on or after July, 2007, the 25% rule requires cost reduction for LTACHs that admit more than 25% of LTACH admissions from a single general acute care hospital. This rule would only impact the reimbursement to the LTACH under a lesser payment, but would not impact the classification of the LTACH. The Bipartisan Budget Act of 2013, however, delayed application of the 25% rule, and implementation of the rule was suspended through Fiscal Year 2017 (October 1, 2016 – September 30, 2017) under the 21st Century Cures Act. In the Fiscal Year 18 Medicare Final Rule, CMS implemented a regulatory moratorium on the implementation of the 25% threshold policy through September 31, 2018. As such, there is a moratorium on the LTACH having to adhere to the 25% threshold rule at this time.

The moratorium on LTACH beds was first introduced in the Medicare, Medicaid and SCHIP Extension Act of 2007 which put into place a moratorium on the establishment of long-term care hospitals, long term care satellite facilities and on the increase of long-term care hospital beds in existing long term acute care hospitals or satellite facilities unless a noted exception was met.

The Bipartisan Budget Act of 2013 provided for an extension of the moratorium on establishment of and any increase in beds for LTACHs for the time period of January 1, 2015 – September 30, 2017.

The Protecting Access to Medicare Act of 2014, amended the time period by striking "January 1, 2015" and inserting the date of enactment of April 2014, but did not amend the end date of September 30, 2017.

Therefore, the LTACH bed moratorium expired on September 30, 2017.

For Fiscal Year 2017 (July 1, 2016 – June 30, 2017), Regional One Health referrals account for 88 of Regional One Extended Care Hospital's discharges.

The floor plan for Turner Tower as it currently exists:

Building	Floor #	Type of Unit	Licensed Beds	Staffed Beds
Turner	4	LTACH	24	21
	3	Rehab	24	24
	2	Rehab/LTACH	6*	0
	G	Burn Unit	14	14
	B	Detention Unit	10	10
Total Beds			78	69

Note: An application was recently approved to convert these 6 rehab beds to 6 LTACH beds.

The Floor Plan for Turner Tower, if this application is approved:

Building	Floor #	Type of Unit	Licensed Beds	Staffed Beds
Turner	4	LTACH	24	21
	3	LTACH	24	24
	2	LTACH	6	0
	G	Burn Unit	14	14
	B	Detention Unit	10	10
Total Beds			78	69

If this application is approved, the applicant will eventually have a fifty-four (54) private bed LTACH located in the Turner Tower, and the twenty-four (24) rehab beds will be relocated. The decision has not been reached as to where those beds will be relocated.

2) Ownership structure;

Response: Regional Med Extended Care Hospital, LLC ("Applicant"), 890 Madison Avenue, 4th Floor, Memphis (Shelby County), Tennessee 38103, is owned by Shelby County Health Care Corporation.

3) Service area;

Response: The facility's existing service area is primarily Shelby County, Tennessee, plus coterminous counties in Mississippi and Arkansas.

As the service being provided is very specialized, patients originate from a wide geographic area. A few of our patients originate in some of the western counties in Tennessee and Missouri and Alabama, but not enough to be included in the primary service area. As shown on Attachment B.Need.C, in 2015, approximately 83% of the Applicant's patients from Tennessee originated from Shelby County, approximately 53% of all patients originated from Shelby County, approximately 63% of its patients originated from Tennessee and approximately 37% of its patients came from out of state. Regarding the out of state patients, about 57% originated from Mississippi, and about 40% came from Arkansas.

The approval of these beds is not expected to alter the existing service area of the Applicant.

4) Existing similar service providers;

Response: There are now only three (3) LTACH providers in Memphis, including:

30 beds at Baptist Memorial Restorative Care Hospital;
39 beds at Select Specialty Hospital (located within St. Francis Hospital); and
24 beds at the Applicant's facility (historically, staffed for only 21 beds).

The 36 beds at Methodist have closed, and the Applicant receives patient referrals from Methodist hospital now. Additionally, Select Specialty has voluntarily surrendered a 24 bed approved CON.

5) Project cost;

Response: The estimated project cost is anticipated to be approximately $8,731,750, including filing fee. The clear majority of these costs involve ongoing lease costs. Very little "new" resources are required for this project. The project will be integrated into an existing lease, which expires in September, 2018. While the lease does contain provisions for term renewal, the original term of the lease for this 24 bed addition is approximately one year, the lease payments for which will amount to considerably less than the FMV approximation ($6,210,000) given in the project.

6) Funding;

Response: There is no construction, and minimal "renovation," which entails the hanging of a sign indicating where the Applicant's beds will be on the 3rd Floor.

7) Financial Feasibility including when the proposal will realize a positive financial margin; and

Response: Based on the Year 1 budget projections, and assuming the project is approved and is initiated within the timeframe as indicated, the long term acute care hospital is anticipated to realize a positive cash flow in the first year following completion of the addition. We believe the additional beds will fill up quickly, when opened.

8) Staffing.

Response: The LTACH is currently staffed for 24 beds, but has been approved for an additional 6 beds. The chart below demonstrates the staffing model for both 30 and 54 beds.

Position Classification	Existing FTE 30 beds	Projected FTE (54 beds Year 1)	Avg Wage $ (contractual rate)	Avg Wage $ Area/State
RN	53.3	91.3	32.71	31.75
CNA	10.1	19.9	13.23	12.95
Patient Care Extern	0.5	0.9	18.69	31.75
Dir. Respiratory Care	1.0	2.0	42.52	31.75
Liaison Nurse	2.0	4.0	34.88	31.75
Lead Respiratory Therapist	1.0	2.2	29.42	31.75
Occupational Therapist	0.8	1.6	47.67	31.75
Physical Therapist	0.9	1.8	48.18	31.75
Speech Pathologist	1.0	1.9	47.44	31.75
Patient Care Coordinator	3.5	7.4	30.35	31.75
Resp Ther/RRT	10.2	20.1	24.19	31.75
Medical Assistant	2.0	3.9	13.91	12.95
Physical Ther Asst	1.1	2.2	29.88	31.75
Resp Ther Tech/Cert	1.0	2.0	23.74	31.75
Patient Serv Clerk	5.5	11.1	14.57	12.95
a. Total Direct Care	93.8	172.3		
Nursing Clin Supv	1.0	1.0	45.67	43.95
Chief Nursing Officer	1.0	1.0	58.85	43.95
Dir HIM	1.0	1.0	37.02	43.95
Case Mgr/RN	1.1	3.0	33.97	43.95
HIM Coding Spec	0.1	0.1	22.00	12.95
Admitting Coordinator	1.0	1.0	19.85	12.95
Pre-Certification Nurse	1.9	1.9	33.65	12.95
CMS Data Coordinator	1.0	1.0	19.31	12.95
Admin Secretary	0.0	0.0	16.50	12.95
b. Total Non-Direct	8.1	10.0		
Contracted Therapy				
Contracted Med Dir/Diet.				
c. Total Contractual	0.0	0.0		
Total Staff (a + b + c)	101.9	182.3		

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B. of this application. Please summarize in one page or less each of the criteria:

1) Need;

Response: The addition of twenty-four (24) beds, within a physical space layout that provides for more efficient care coordination for the hospital and patients, will permit greater access to care for this highly acute patient population with a need for an extended, acute care stay.

Being part of a health care organization that serves as a Level One Trauma Center and Regional Burn Center, Regional One Health has a need for long term acute care services within its post-acute complement. Patients with extended care needs related to ventilator management and weaning are best served in the long term care environment; with Regional One Health Extended Care Hospital demonstrating vent weaning well below the national average.

More to the point of Need for this project, Methodist Hospital closed its 36 bed LTACH recently and now refers their long term care hospital patients to the Applicant. Since the HSDA (or its predecessor, the Health Facilities Commission) originally approved that facility, it follows that the need for the twenty-four (24) beds requested in the instant application has already been positively addressed. This is especially true since Select Specialty Hospital, another LTACH in Memphis, recently (July 10, 2017) voluntarily surrendered its approved CON for an additional 24 beds. In effect, sixty (60) LTACH beds that have already been approved through the Certificate of Need process have been taken away from the inventory of needed beds in Memphis. This application, if approved, will "replace" twenty-four (24) of those beds.

2) Economic Feasibility;

Response: Regional One Health Extended Care Hospital has demonstrated successful financial outcomes within its first years of operation. It is anticipated that the addition of these twenty-four (24) beds will also realize the same success. Based on the Year 1 budget projections, assuming the project is approved and is initiated within the timeframe as indicated, the long term acute care hospital is anticipated to realize a positive cash flow in the first year. There is minimal capital outlay for the twenty-four (24) beds to be added to the LTACH, and this addition provides additional employment opportunities to the healthcare community.

3) Appropriate Quality Standards; and

Response: Regional One Health Extended Care Hospital monitors quality standards through its Quality Assessment and Performance Improvement Program as well as through mandatory Quality reporting to the State of Tennessee and the Centers for Medicare and Medicaid Services (CMS). Benchmarks regarding Core Operational Measures, Key Financial Measures and Clinical Benchmarking are currently maintained by the hospital. The additional beds would be monitored under the same program to analyze, identify and address areas which are in need of improvement.

4) Orderly Development to adequate and effective health care.

Response: While all four LTACHs in Memphis operated at approximately 85.1% utilization in 2015 (latest JARs), the Applicant is owned by the only hospital in Memphis that operates a Level One Trauma Center and a Regional Burn Center. Therefore, the Applicant facility is administratively, operationally, and physically closer to a referring facility with patients who have extended care needs. Further, one of the four LTACHS (Methodist Extended Care) closed on June 20, 2016 and all LTACH patients were discharged. The approval of this application will ensure LTACH patients continue to receive the care they need.

C. Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

Response: The Applicant is not requesting Consent Calendar.

4. **SECTION A: PROJECT DETAILS** 31

A. **Owner of the Facility, Agency or Institution**

Shelby County Health Care Corporation — Name
901-545-7676 — Phone Number

877 Jefferson Avenue — Street or Route
Shelby — County

Memphis — City
TN — State
38103 — Zip Code

B. **Type of Ownership of Control (Check One)**

A.	Sole Proprietorship		F.	Government (State of TN or Political Subdivision)	
B.	Partnership		G.	Joint Venture	
C.	Limited Partnership		H.	Limited Liability Company	X
D.	Corporation (For Profit)		I.	Other (Specify) a component unit of Shelby County, TN	X (see below)
E.	Corporation (Not-for-Profit)				

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at https://tnbear.tn.gov/ECommerce/FilingSearch.aspx. **Attachment Section A-4A.**

Describe *the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.* **Regional Med Extended Care Hospital, LLC ("Applicant"), 890 Madison Avenue, 4th Floor, Memphis (Shelby County), Tennessee 38103, is an LLC, and is 100% owned by Shelby County Health Care Corporation, a corporation.**

5. **Name of Management/Operating Entity (If Applicable)**

Not applicable – self-managed
Name

Street or Route
County

City
State
Zip Code

Website address: https://murer.com/

For new facilities or existing facilities *without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.* **Not Applicable.**

The Applicant was managed under contract previously, but that contract has expired. The Applicant will self-manage the facility. Dollar amounts are included on the Projected Data Charts (both Project and Total Facility) which reflect our best estimate of what it will cost the Applicant to self-manage the facility.

6A. Legal Interest in the Site of the Institution (Check One)

A.	Ownership	____	D.	Option to Lease	____
B.	Option to Purchase	____	E.	Other (Specify) _____	____
C.	Lease of _5__ Years	__x__		_____	

Check appropriate line above: *For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option to Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** on the date of the Agency's consideration of the certificate of need application. **See Attachments A.6.A.1 and A.6.A.2.**

6B. Attach **a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site** on an 8 1/2" x 11" sheet of white paper, single or double-sided. ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

1) Plot Plan **must include**:

   a. Size of site (***in acres***); approximately 18.55Acres (entire hospital complex)

   b. Location of structure on the site; Applicant located in Turner Tower

   c. Location of the proposed construction/renovation; on plans; and (n/a)

   d. Names of streets, roads or highway that cross or border the site. Noted

2) Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8 ½ by 11 sheet of paper or as many as necessary to illustrate the floor plan.

3) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response: The facility is located on the 4th Floor of the Turner Tower. The requested beds will be located on the 3rd Floor of the Turner Tower. The site is bounded by Jefferson Avenue, N. Pauline Street, Madison Avenue, and N. Dunlap Avenue. The site is downtown Memphis, close to I-240 and is readily accessible to patients, family members, and other health care providers. Other hospitals are located nearby. This attachment also shows that other providers even own plots of land located within this block. The patient floors in Turner Tower have the same footprint, meaning that the footprint of floors 2, 3, and 4 are exactly the same, and each floor can accommodate 24 private rooms, max.

See Attachments A.6.B.1 and A.6.B.2.

7. Type of Institution (Check as appropriate--more than one response may apply)

A.	Hospital (Specify) LTACH	X	H.	Nursing Home	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		I.	Outpatient Diagnostic Center	
C.	ASTC, Single Specialty		J.	Rehabilitation Facility	
D.	Home Health Agency		K.	Residential Hospice	
E.	Hospice		L.	Nonresidential Substitution-Based Treatment Center for Opiate Addiction	
F.	Mental Health Hospital				
G.	Intellectual Disability Institutional Habilitation Facility ICF/IID		M.	Other (Specify)	

Check appropriate lines(s).

8. Purpose of Review (Check appropriate lines(s) – more than one response may apply)

A.	New Institution		F.	Change in Bed Complement [*Please note the type of change by underlining the appropriate response:* **Increase**, *Decrease, Designation, Distribution, Conversion, Relocation]*	x
B.	Modifying an ASTC with limitation still required per CON				
C.	Addition of MRI Unit				
D.	Pediatric MRI				
E.	Initiation of Health Care Service as defined in T.C.A. §68-11-1607(4) (Specify)		G.	Satellite Emergency Dept.	
			H.	Change of Location	
			I.	Other (Specify)	

9. Medicaid/TennCare, Medicare Participation

MCO Contracts [Check all that apply]

_x_ AmeriGroup _x_ United Healthcare Community Plan _x_ BlueCare _x_ TennCare Select

Medicare Provider Number *44-2017*

Medicaid Provider Number *Q019830*

Certification Type *Hospital*

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare?

Medicare __Yes __No _x_N/A Medicaid/TennCare __Yes __No _x_N/A

10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.

	Current Licensed	*Beds Staffed*	*Beds Proposed*	**Beds Approved*	***Beds Exempted*	*TOTAL Beds at Completion*
1) Medical						
2) Surgical						
3) ICU/CCU						
4) Obstetrical						
5) NICU						
6) Pediatric						
7) Adult Psychiatric						
8) Geriatric Psychiatric						
9) Child/Adolescent Psychiatric						
10) Rehabilitation						
11) Adult Chemical Dependency						
12) Child/Adolescent Chemical Dependency						
13) Long-Term Care Hospital	24	24	24	6		54
14) Swing Beds						
15) Nursing Home – SNF (Medicare only)						
16) Nursing Home – NF (Medicaid only)						
17) Nursing Home – SNF/NF (dually certified Medicare/Medicaid)						
18) Nursing Home – Licensed (non-certified)						
19) ICF/IID						
20) Residential Hospice						
TOTAL	24	24	24	6		54

**Beds approved but not yet in service* ***Beds exempted under 10% per 3 year provision*

Note: The six (6) beds on the 2nd Floor were approved in December, 2017, and should go on line soon.

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services. **Response:** Attachment Section A-10.

C. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.

CON Number(s)	CON Expiration Date	Total Licensed Beds Approved
CN1708-025A	Anticipated 01/2021	6

11. **Home Health Care Organizations** – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply: **(Not Applicable)**

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson				Lauderdale			
Bedford				Lawrence			
Benton				Lewis			
Bledsoe				Lincoln			
Blount				Loudon			
Bradley				McMinn			
Campbell				McNairy			
Cannon				Macon			
Carroll				Madison			
Carter				Marion			
Cheatham				Marshall			
Chester				Maury			
Claiborne				Meigs			
Clay				Monroe			
Cocke				Montgomery			
Coffee				Moore			
Crockett				Morgan			
Cumberland				Obion			
Davidson				Overton			
Decatur				Perry			
DeKalb				Pickett			
Dickson				Polk			
Dyer				Putnam			
Fayette				Rhea			
Fentress				Roane			
Franklin				Robertson			
Gibson				Rutherford			
Giles				Scott			
Grainger				Sequatchie			
Greene				Sevier			
Grundy				Shelby			
Hamblen				Smith			
Hamilton				Stewart			
Hancock				Sullivan			
Hardeman				Sumner			
Hardin				Tipton			
Hawkins				Trousdale			
Haywood				Unicoi			
Henderson				Union			
Henry				Van Buren			
Hickman				Warren			
Houston				Washington			
Humphreys				Wayne			
Jackson				Weakley			
Jefferson				White			
Johnson				Williamson			
Knox				Wilson			
Lake							

12. Square Footage and Cost Per Square Footage Chart (Not Applicable – no construction/renovation)

Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
New Staff Support							
New Therapy							
New Patient Rooms							
Unit/Department GSF Sub-Total							
Other GSF Total							
Total GSF							
*Total Cost							
**Cost Per Square Foot							
Cost per Square Foot Is Within Which Range *(For quartile ranges, please refer to the Applicant's Toolbox on www.tn.gov/hsda)*					☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile	☐ Below 1st Quartile ☐ Between 1st and 2nd Quartile ☐ Between 2nd and 3rd Quartile ☐ Above 3rd Quartile

* The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.

** Cost per Square Foot is the construction cost divided by the square feet. Please do not include contingency costs.

13. MRI, PET, and/or Linear Accelerator (Not Applicable)

1. Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding a MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000 and/or
2. Describe the acquisition of any Positron Emission Tomographer (PET) or Linear Accelerator if initiating the service by responding to the following:

A. Complete the chart below for acquired equipment.

☐ Linear Accelerator	Mev _____ Types:	☐ SRS ☐ IMRT ☐ IGRT ☐ Other _____
	Total Cost*: _____	☐ By Purchase ☐ By Lease Expected Useful Life (yrs) ___
	☐ New ☐ Refurbished	☐ If not new, how old? (yrs) _____
☐ MRI	Tesla: ____ Magnet:	☐ Breast ☐ Extremity ☐ Open ☐ Short Bore ☐ Other _____
	Total Cost*: _____	☐ By Purchase ☐ By Lease Expected Useful Life (yrs) ___
	☐ New ☐ Refurbished	☐ If not new, how old? (yrs) _____
☐ PET	☐ PET only ☐ PET/CT ☐ PET/MRI	
	Total Cost*: _____	☐ By Purchase ☐ By Lease Expected Useful Life (yrs) ___
	☐ New ☐ Refurbished	☐ If not new, how old? (yrs) _____

* As defined by Agency Rule 0720-9-.01(13)

B. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

C. Compare lease cost of the equipment to its fair market value. Note: Per Agency Rule, the higher cost must be identified in the project cost chart.

D. Schedule of Operations:

Location	Days of Operation (*Sunday through Saturday*)	Hours of Operation (*example: 8 am – 3 pm*)
Fixed Site *(Applicant)*		
Mobile Locations *(Applicant)*		
(Name of Other Location)		
(Name of Other Location)		

E. Identify the clinical applications to be provided that apply to the project.

F. If the equipment has been approved by the FDA within the last five years provide documentation of the same.

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care." Further standards for guidance are provided in the State Health Plan developed pursuant to T.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper, single-sided or double sided.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. ***If a question does not apply to your project, indicate "Not Applicable (NA)."***

QUESTIONS

SECTION B: NEED

A. Provide a response to each criterion and standard in Certificate of Need Categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the Tennessee Health Services and Development Agency or found on the Agency's website at http://www.tn.gov/hsda/article/hsda-criteria-and-standards.

Response: See Attachment B.Need.A.

B. Describe the relationship of this project to the applicant facility's long-range development plans, if any, and how it relates to related previously approved projects of the applicant.

Response: The Applicant constantly monitors patient needs and healthcare delivery systems at our facility. While there are no adopted long-range development plans, the fact that sixty (60) approved LTACH beds in Memphis have been recently closed or surrendered impacts patients we serve. The addition of these twenty-four (24) beds is a first step in providing continuing care for the long term acute care hospital patients in need of such services.

C. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the Border States, if applicable. **Attachment Section B.Need.C.**

Response: Please complete the following tables, if applicable:

Service Area Counties	**Historical Utilization-County Residents**	**# and % of total patients**
County #1	Shelby	98 and 50.0%
	Other Tennessee Counties	26 and 13.3%
Mississippi		37 and 18.9%
Arkansas		23 and 11.7%
	Other States	12 and 6.1%
Total		196 and 100%

Service Area Counties	**Projected Utilization-Co. Residents-24 beds**	**# and % of total patients**
County #1	Shelby	96 and 50.0%
	Other Tennessee Counties	24 and 12.5%
Mississippi		36 and 18.8%
Arkansas		24 and 12.5%
	Other States	12 and 6.3%
Total		192 and 100%

Service Area Counties	**Projected Utilization-Co. Residents-54 beds**	**# and % of total patients**
County #1	Shelby	216 and 50.0%
	Other Tennessee Counties	54 and 13.5%
Mississippi		81 and 18.7%
Arkansas		54 and 11.9%
	Other States	27 and 6.0%
Total		432 and 100%

The chart below shows that, considering Shelby County, only, there would be a bed need for approximately 49 LTACH beds in 2019, and there currently exist 93 LTACH beds, plus the Applicant has been approved for an additional six (6) beds. See attached TDOH LTACH Bed Need Chart.

	Population		**0.5 LTACH bed X (10,000 population)**		**Current licensed & approved beds**	**Net Need**	
	2018	**2020**	**2018**	**2020**	**2018**	**2018**	**201920**
Shelby County	970,212	981,022	49	50	99	(50)	(49)

The facility's existing service area is primarily Shelby County, Tennessee, plus border counties of Mississippi and Arkansas. However, as the service being provided is very specialized, patients originate from a wide geographic area. A few of our patients originate in some of the western counties in Tennessee and Missouri and Alabama, but not enough to be included in the primary service area. As shown on Attachment B.Need.C, in 2015, approximately 83% of the Applicant's patients from Tennessee originated from Shelby County, approximately 53% of all patients originated from Shelby County, approximately 63% of its patients originated from Tennessee and approximately 37% of its patients came from out of state. Regarding the out of state patients, about 57% originated from Mississippi, and about 40% came from Arkansas. The approval of these relatively few beds is not expected to alter the existing service area of the Applicant.

Also, the Historic Utilization chart above is based on the 2016 JAR, which is the latest JAR available on the State's website.

Finally, regarding our service area, due to the unique and specialized nature of the services provided, LTACHs draw from a wide geographic area. All of the LTACHs in West Tennessee are in Shelby County, and the Applicant's primary service area consists of Shelby County and coterminous counties in Mississippi and Arkansas. A question has arisen regarding LTACHs geographically close to Memphis. There are no LTACHs in Tennessee between Memphis and Nashville. The closest LTACHs to Memphis are out of state, as explained below.

In searching the American Hospital Directory, there are only three LTACHs within 75 miles of zip code 38103 (the Applicant's zip code), and all three are in Memphis (Shelby County):

Baptist Memorial Restorative Care Hospital (30 beds);
Regional One Health Extended Care Hospital (24 beds); and
Select Specialty Hospital – Memphis (39 beds).

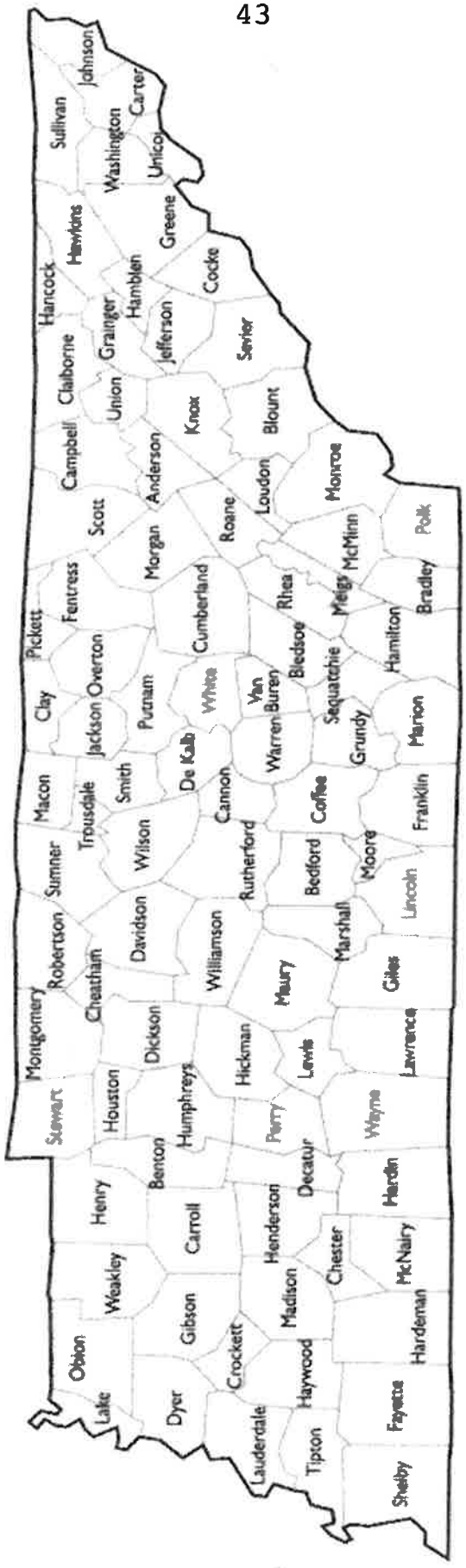
Expanding the search to 100 miles, there is only one additional LTACH in addition to the above which is Advanced Care Hospital of White County (27 beds in Searcy, Arkansas).

Extended to 120 miles, there is only one additional LTACH in addition to the above which is AMG Specialty Hospital of Greenwood (40 beds in Greenwood, Mississippi).

Extending to 150 miles of zip code 38103, the total list of LTACHs is as follows:

Baptist Memorial Restorative Care Hospital (30 beds in Memphis);
Regional One Health Extended Care Hospital (24 beds in Memphis);
Select Specialty Hospital – Memphis (39 beds in Memphis);
Advanced Care Hospital of White County (27 beds in Searcy, Arkansas);
AMG Specialty Hospital of Greenwood (40 beds in Greenwood, Mississippi);
Allegiance Specialty Hospital of Greenville (39 beds in Greenville, Mississippi);
Baptist Health Extended Care Hospital (55 beds in Little Rock, Arkansas); and
Cornerstone Hospital Little Rock (40 beds in Little Rock, Arkansas).

County Level Map



D. 1). a) Describe the demographics of the population to be served by the proposal.

Response: Shelby County is an urban county with almost one million population covering approximately 763 square miles in the lower left corner of Tennessee. Memphis is the county seat. Approximately 30% of the population has a college degree or higher, and about 20% of the population lives in poverty. Approximately 12.5% of the population is over the age of 65, about 41% is white, and approximately 54% is black or African American. The median value of owner-occupied housing is $130,000 (from 2011 – 2015), and there are about 347,224 households in Shelby County (from 2011 – 2015). Please see Attachment B.Need.D.1.a for more quick facts about Shelby County.

b) Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data: http://www.tn.gov/health/article/statistics-population

TennCare Enrollment Data: http://www.tn.gov/tenncare/topic/enrollment-data

Census Bureau Fact Finder: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Response: See the following chart:

Demographic Variable/Geogra-phic Area	Department of Health/Health Statistics							Bureau of the Census				TennCare	
	Total Population-Current Year	Total Population-Projected Year	Total Population-% Change	*Target Population-Current Year	*Target Population-Project Year	*Target Population-% Change	Target Population Projected Year as %	Median Age	Median Household Income	Person Below Poverty Level	Person Below Poverty Level as % of	TennCare Enrollees	TennCare Enrollees as % of Total
Shelby County	970212	981022	+1.1	125389	135234	+7.9	13.3	34.6	$46,224	140398	16.0	249268	25.8
Service Area Total	970212	981022	+1.1	125389	135234	+7.9	13.3	34.6	$46,224	140398	16.0	249268	25.8
State of TN Total	6960524	7112424	+2.2	1175938	1267962	7.8	17.3	38.4	$45,219	1117594	15.9	1412063	20.5

** Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child and adolescent psychiatric services will serve the Population Ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2016, then default Projected Year is 2020.*

Long Term Acute Care Hospital services affect all ages. However, for purposes of this question, the "Target Population" will include those aged 65 and over. The chart above reflects that assumption.

Total Population, Current Year shows data for 2018, and Total Population, Target Year, shows data for 2020.

2) Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: Shelby County, TN is a medically underserved area, according to Health Resources and Services Administration. The addition of more LTACH beds in the county will add more health care services in the county. Further, while the Applicant will serve all people who present and qualify for nursing services, such services normally target the elderly population. While the elderly population (aged 65+) makes up 17.3% of the population of Tennessee, that same segment of the population represents only 13.3% of the population of Shelby County. Obviously, the population of Shelby County is statistically younger than is the population of the state of Tennessee. Since there are twice as many patients in the existing LTACHs in 2015 than the entire bed need for Shelby County indicated, LTACH patients are obviously originating from other areas. This is in keeping with statements made here and elsewhere about the unique nature of LTACH services, and the wide geographic draw such facilities have. As an example, in 2015 while there were 95 patients from Shelby County at our facility, there were another 38 patients from border counties of Mississippi and 27 patients from border counties of Arkansas. Therefore, the population being served by the Applicant, and these addition requested beds, are in more need of such services than just the population of only Shelby County indicates. The unique nature of the LTACH services we provide indicates special needs for all of the patients we serve, not just those from Shelby County. See Attachment B.Need.D.2 for a list of the MUA tracts and Attachment B.Need.D.3 for a listing of primary care shortage areas in Shelby County.

E. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply to projects that are solely relocating a service.

Response: Selected JAR utilization/statistics for the first 3 LTACHS located in Shelby County (not the Applicant) and listed in that order are indicated in the chart below. These numbers are taken off the most recent JARs available (2015).

The Applicant (Regional MED Extended Care Hospital, LLC, d/b/a Regional One Health Extended Care Hospital, noted as "Regional Med" in the chart below) lists data for 2017, our most recent data. It is important to note that the Applicant was staffing only 21 beds until recently, when demand necessitated the staffing of the additional 3 beds. This restriction is a reflection of the layout of our beds, and staffing the additional three (3) beds on the fourth floor originally resulted in financial loss for those 3 beds. Therefore, the fact that we averaged 20.21 patients in a 21 bed facility is indicative of how our existing staffed beds are utilized to capacity.

Facility	# beds	# pts	Occ Rate	Gross	Adj.	Net
Baptist	30	22.89	76.3%	$6,987.64	$5,283.73	$1,703.91
Methodist	36	31.46	87.4%	$4,023.54	$2,661.94	$1,361.60
Select Specialty	39	36.66	94.0%	$10,507.78	$7,388.76	$3,119.02
Regional MED	24	20.21	84.2%	$8,499.58	$6,683.20	$1,816.38
Total	129	111.22	86.2%			

NOTE: Gross = Gross Operating Revenue per Patient Day
Adj. = Contractual Adjustments per Patient Day
Net = Net Operating Revenue per Patient Day

Also, Methodist LTACH closed on June 20, 2016, and its license has been surrendered. In addition, Select Specialty Hospital recently (July 10, 2017) voluntarily surrendered its approved CON for 24 additional LTACH beds. As a result, sixty (60) approved LTACH beds have recently been surrendered to either the Board of Licensing Health Care Facilities or the Health Services and Development Agency.

Other utilization data includes the following:

LTACH UtilizationTrends-2014-2016

Facility	Licensed Beds	2014 Admissions	2015 Admissions	2016 Admissions	2014 Average Length of Stay	2015 Average Length of Stay	2016 Average Length of Stay
Baptist	30	259	250	214	32.8	33.4	32.9
Methodist	36	435	424	172	27.0	27.1	12.9
Select Specialty	39	422	265	344	32.5	50.5	30.0
Regional MED	24	63	181	196	27.2	37.9	36.5
Total	129	1179	1120	926	30.3	35.8	31.7

Source: LTACH JAR, 2014-2016 (Note: Methodist closed in June, 2016)

Please note in both the preceding chart and the following chart that the Applicant, Regional MED LTACH, was not open in 2013, and was open for only part of 2014.

LTACH UtilizationTrends-2014-2016

Facility	Licensed Beds	2014 Patient Days	2015 Patient Days	2016 Patient Days	'14- '16 % change	2014 % Occupancy	2015 % Occupancy	2016 % Occupancy
Baptist	30	8,499	8,354	7,041	-17.2%	77.2%	76.3%	64.3%
Methodist	36	11,752	11,485	4,808	-59.1%	89.4%	87.4%	36.6%
Select Specialty	39	13,724	13,388	10,311	-24.9%	96.4%	94.0%	72.4%
Regional MED	24	1,711	6,854	7,160	+318.5%	19.5%	78.2%	81.7%
Total	129	35,686	40,081	29,320	-17.8%	75.7%*	85.1%	62.3%

Source: LTACH JAR, 2014-2016 (Note: Methodist closed in June, 2016)

In addition, the total equivalent inpatient cost per day at Regional One Health is $3,137. The total operating expenses per day for Regional One Health Extended Care Hospital is $1,730. With a daily differential of $1,407 multiplied by the length of stay as reported on the most recently filed cost report of 33.75 days, the savings to retaining the patient at the short term acute care venue would average $47,486 per Medicare patient.

Further, since our most recent ALOS is 33.75 days, each bed would "turn over" 10.8 times per year. This means that the addition of 24 LTACH beds, operating at 100% utilization with Medicare patients, would result in potential of annual savings to Medicare of $12,308,371.20.

F. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: Based on licensed beds (24), the Applicant has operated at 78.4%, 81.7%, and 84.2% during 2015, 2016, and 2017, respectively. These respective rates would increase to 89.5%, 92.4% and 96.3% based on staffed beds (21). As stated, the Applicant has recently staffed all 24 of its licensed beds. In any regard, the increase in occupancy rate at our hospital, coupled with the closing of Methodist and surrender of beds at Select, indicates a need for more beds.

The Applicant anticipates the occupancy rates for the first two years following completion of the project as follows: Total Facility, 87.4% each year; and the 24 bed addition, only, 82.6% each year. These estimates are based on actual utilization experience of the former management company when adding similar numbers of beds to similarly-sized facilities in the past. The only assumption being made is that all of the similar additions that the management company have experienced in the past will replicate on this project. There is nothing known that indicates the facility, the locale, or the population to be served is statistically different from past experience. Further, the recent loss of LTACH beds (detailed below) indicates that the new beds will be filled quickly, when opened.

Finally, Methodist LTACH (36 beds) closed on June 20, 2016, and its license has been surrendered. In addition, Select Specialty Hospital recently (July 10, 2017) voluntarily surrendered its approved CON for 24 additional LTACH beds. As a result, sixty (60) approved LTACH beds have recently been surrendered to either the Board of Licensing Health Care Facilities or the Health Services and Development Agency.

SECTION B: ECONOMIC FEASIBILITY

A. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

1) All projects should have a project cost of at least $15,000 (the minimum CON Filing Fee). (See Application Instructions for Filing Fee).

Response: The filing fee amounts to $51,750, and the check is attached to the application. In fact, the filing fee check amount exceeds the actual filing fee by $1,840, and the Applicant requests a refund of that amount. We apologize for submitting the higher amount.

2) The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

Response: The Project Costs Chart lists the fair market value of the leased space applicable to this project. The FMV number is much higher than the lease costs for that space.

3) The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

Response: There is no moveable equipment as suggested by this question.

4) Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

Response: Not applicable, as there is neither construction nor renovation involved with this project.

5) For projects that include new construction, modification, and/or renovation—**documentation must be** provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:

a) A general description of the project;

b) An estimate of the cost to construct the project;

c) A description of the status of the site's suitability for the proposed project; and

d) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

Response: Please see Attachment B.EconomicFeasibility.A.5.

Supplemental #1
January 29, 2017
2:07 PM

PROJECT COST CHART

A.	Construction and equipment acquired by purchase:	
1.	Architectural and Engineering Fees	
2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	40,000
3.	Acquisition of Site	
4.	Preparation of Site	
5.	Total Construction Costs	
6.	Contingency Fund	
7.	Fixed Equipment (Not included in Construction Contract)	800,000
8.	Moveable Equipment (List all equipment over $50,000 as separate attachments)	400,000
9.	Other (Specify) _____	
B.	Acquisition by gift, donation, or lease:	
1.	Facility (inclusive of building and land) (FMV of leased space)	6,210,000
2.	Building only	
3.	Land only	
4.	Equipment (Specify)_ _____ (by lease)	1,230,000
5.	Other (Specify) _____	
C.	Financing Costs and Fees:	
1.	Interim Financing	
2.	Underwriting Costs	
3.	Reserve for One Year's Debt Service	
4.	Other (Specify) _____	
D.	Estimated Project Cost (A+B+C)	**8,680,000**
E.	CON Filing Fee (Overpaid by $1,840)	49,910
F.	Total Estimated Project Cost (D+E) **TOTAL**	**8,729,910**

B. Identify the funding sources for this project.

Check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment Section B-Economic Feasibility-B.)***

__ 1) Commercial loan – Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

__ 2) Tax-exempt bonds – Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ 3) General obligation bonds – Copy of resolution from issuing authority or minutes from the appropriate meeting;

__ 4) Grants – Notification of intent form for grant application or notice of grant award;

__ 5) Cash Reserves – Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or

_x 6) Other – Identify and document funding from all other sources.

Response: The majority of Project Costs ($7,440,000) represent the Fair Market Value of the lease, which is part of the annual budget for the Applicant. The remaining amount ($1,240,000) will be paid with Cash Reserves of the Applicant. Please see Attachment B.EconomicFeasibility.B.

C. Complete Historical Data Charts on the following two pages—***Do not modify the Charts provided or submit Chart substitutions!***

Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. **Only complete one chart if it suffices.**

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

HISTORICAL DATA CHART

□ **Total Facility**
□ Project Only

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

		2015	2016	2017
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) Patient Days	6,864	7,160	7,378
B.	Revenue from Services to Patients			
1.	Inpatient Services	$45,102,368	$54,535,080	$62,709,904
2.	Outpatient Services			
3.	Emergency Services			
4.	Other Operating Revenue (Specify)_prior year adjustments			
	Gross Operating Revenue	$45,102,368	$54,535,080	$62,709,904
C.	Deductions from Gross Operating Revenue			
1.	Contractual Adjustments	$29,817,726	$40,551,332	$48,430,137
2.	Provision for Charity Care		94,113	279,963
3.	Provisions for Bad Debt	686,949	842,985	598,558
	Total Deductions	$30,504,675	$41,488,430	$49,308,658
NET OPERATING REVENUE		$14,597,693	$13,046,650	$13,401,246
D.	Operating Expenses			
1.	Salaries and Wages			
a.	Direct Patient Care	3,963,368	4,835,706	5,343,636
b.	Non-Patient Care	659,690	481,125	531,661
2.	Physician's Salaries and Wages			
3.	Supplies	1,690,912	1,889,651	1,966,486
4.	Rent			
a.	Paid to Affiliates	480,000	480,000	503,500
b.	Paid to Non-Affiliates	515,471	370,600	444,568
5.	Management Fees:			
a.	Paid to Affiliates			
b.	Paid to Non-Affiliates	484,234	502,643	504,478
6.	Other Operating Expenses	3,468,802	3,844,545	3,472,418
	Total Operating Expenses	$11,262,477	$12,404,269	$12,766,746
E.	**Earnings Before Interest, Taxes and Depreciation**	$3,335,216	$642,381	$634,500
F.	Non-Operating Expenses			
1.	Taxes	$	$	$
2.	Depreciation			
3.	Interest			
4.	Other Non-Operating Expenses			
	Total Non-Operating Expenses	$	$	$
NET INCOME (LOSS)		$3,335,216	$642,381	$634,500

Chart Continues Onto Next Page

NET INCOME (LOSS)	$3,335,216	$642,381	$634,500
G. Other Deductions			
1. Annual Principal Debt Repayment	$	$	$
2. Annual Capital Expenditure			
Total Other Deductions	$	$	$
NET BALANCE	$3,335,216	$642,381	$634,500
DEPRECIATION	$	$	$
FREE CASH FLOW (Net Balance + Depreciation)	$3,335,216	$642,381	$634,500

☐ **Total Facility**
☐ Project Only

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	**2015**	**2016**	**2017**
1. Professional Services Contract	$528,032	$1,387,215	$1,322,488
2. Contract Labor	118,455	141,661	29,981
3. Imaging Interpretation Fees	66,270	70,107	103,065
4. Benefits	1,086,623	1,066,808	1,019,357
5. General & Administrative	934,746	635,631	429,570
6. Other	734,676	543,123	567,957
Total Other Expenses	**$3,468,802**	**$3,844,545**	**$3,472,418**

D. Complete Projected Data Charts on the following two pages – ***Do not modify the Charts provided or submit Chart substitutions!***

The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. **Only complete one chart if it suffices.**

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

PROJECTED DATA CHART

☐ Total Facility
☐ Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in July (Month).

		Year 1 (2019)	Year 2 (2020)
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) Patient Days.	16,805	16,805
B.	Revenue from Services to Patients		
1.	Inpatient Services	$137,801,340	$137,801,340
2.	Outpatient Services		
3.	Emergency Services		
4.	Other Operating Revenue (Specify)vending, food, rebates		
	Gross Operating Revenue	**$137,801,340**	**$137,801,340**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$106,440,421	$106,440,421
2.	Provision for Charity Care	541,138	541,138
3.	Provisions for Bad Debt	558,982	558,982
	Total Deductions	$107,540,541	$107,540,541
NET OPERATING REVENUE		$30,260,799	$30,260,799
D.	Operating Expenses		
1.	Salaries and Wages		
a.	Direct Patient Care	9,257,073	9,442,214
b.	Non-Patient Care	921,025	939,447
2.	Physician's Salaries and Wages		
3.	Supplies	5,731,175	5,844,575
4.	Rent		
a.	Paid to Affiliates	1,042,500	1,063,350
b.	Paid to Non-Affiliates	440,000	448,800
5.	Management Fees:		
a.	Paid to Affiliates		
b.	Paid to Non-Affiliates	385,295	393,002
6.	Other Operating Expenses	4,131,473	4,214,102
	Total Operating Expenses	$21,908,541	$22,345,490
E.	**Earnings Before Interest, Taxes and Depreciation**	$8,352,258	$7,915,309
F.	Non-Operating Expenses		
1.	Taxes	$	$
2.	Depreciation		
3.	Interest		
4.	Other Non-Operating Expenses		
	Total Non-Operating Expenses	$	$
NET INCOME (LOSS)		$8,352,258	$7,915,309

Chart Continues Onto Next Page

NET INCOME (LOSS)	~~$8,352,258~~	$7,915,309
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$	$
2. Annual Capital Expenditure		
Total Other Deductions	$	$
NET BALANCE	$8,352,258	$7,915,309
DEPRECIATION	$	$
FREE CASH FLOW (Net Balance + Depreciation)	$8,352,258	$7,915,309

□ **Total Facility**
□ Project Only

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	**Year 1 2019**	**Year 2 2020**
1. Professional Services Contract	$1,435,479	$1,464,189
2. Contract Labor	25,000	25,500
3. Imaging Interpretation Fees	95,000	96,900
4. Benefits	1,617,435	1,649,784
5. General and Administrative	500,000	510,000
6. Other	458,559	467,729
Total Other Expenses	**$4,131,473**	**$4,214,102**

NOTE: The amounts under "Paid to Non Affiliates" are the anticipated costs to self-manage the facility.

PROJECTED DATA CHART

☐ Total Facility
☐ Project Only

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in July (Month).

		Year 1 (2019)	Year 2 (2020)
A.	Utilization Data (Specify unit of measure, e.g., 1,000 patient days, 500 visits) Patient Days.	7,240	7,240
B.	Revenue from Services to Patients		
1.	Inpatient Services	$59,368,000	$59,368,000
2.	Outpatient Services		
3.	Emergency Services		
4.	Other Operating Revenue (Specify)Vending, Food, Rebates		
	Gross Operating Revenue	**$59,368,000**	**$59,368,000**
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$45,855,976	$45,855,976
2.	Provision for Charity Care	151,352	151,352
3.	Provisions for Bad Debt	323,592	323,592
	Total Deductions	$46,330,920	$46,330,920
NET OPERATING REVENUE		$13,037,080	$13,037,080
D.	Operating Expenses		
1.	Salaries and Wages		
a.	Direct Patient Care	2,716,820	2,771,156
b.	Non-Patient Care	270,308	275,716
2.	Physician's Salaries and Wages		
3.	Supplies	2,841,752	2,897,364
4.	Rent		
a.	Paid to Affiliates	500,000	510,000
b.	Paid to Non-Affiliates		
5.	Management Fees:		
a.	Paid to Affiliates		
b.	Paid to Non-Affiliates		
6.	Other Operating Expenses	465,200	474,504
	Total Operating Expenses	$6,794,080	$6,928,740
E.	**Earnings Before Interest, Taxes and Depreciation**	$6,243,000	$6,108,340
F.	Non-Operating Expenses		
1.	Taxes	$	$
2.	Depreciation		
3.	Interest		
4.	Other Non-Operating Expenses		
	Total Non-Operating Expenses	$	$
NET INCOME (LOSS)		$6,243,000	$6,108,340

Chart Continues Onto Next Page

Supplemental #1
January 29, 2017

NET INCOME (LOSS)	[illegible]	$6,108,340
G. Other Deductions		
1. Estimated Annual Principal Debt Repayment	$	$
2. Annual Capital Expenditure		
Total Other Deductions	$	$
NET BALANCE	$6,243,000	$6,108,340
DEPRECIATION	$	$
FREE CASH FLOW (Net Balance + Depreciation)	$6,243,000	$6,108,340

□ Total Facility
□ **Project Only**

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	**Year 2019**	**Year 2020**
1. Professional Services Contract	$	$
2. Contract Labor		
3. Imaging Interpretation Fees		
4. Benefits	465,200	474,504
5. General and Administrative		
6. Other		
Total Other Expenses	**$465,200**	**$474,504**

NOTE: The amounts under "Paid to Affiliates" are the anticipated costs to self-manage the facility.

E. 1) Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Previous Year (2016)	Current Year (2017)	Year One	Year Two	% Change (Current Year to Year 2)
Gross Charge *(Gross Operating Revenue/Utilization Data)*	7,616.63	8,499.58	8,197.13	8,197.13	-3.6
Deduction from Revenue *(Total Deductions/Utilization Data)*	5,794.47	6,683.20	6,399.79	6,399.79	-4.2
Average Net Charge *(Net Operating Revenue/Utilization Data)*	1,822.16	1,816.38	1,797.34	1,797.34	-1.0

2) Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

Response: The proposed charges for the total project are reflected in the table above: Year 1, $8,197.13 in gross operating revenue per patient day, $6,399.79 in contractual adjustments per patient day; and $1,797.34 in net operating revenue per patient day. The implementation of this project, coupled with normal increases in costs, will decrease the average net charge per patient day by approximately 1.0% in two years. This decrease is to be expected due to cost efficiencies in operating a larger facility.

In addition, the total equivalent inpatient cost per day at Regional One Health is $3,137. The total operating expenses per day for Regional One Health Extended Care Hospital is $1,730. With a daily differential of $1,407 multiplied by the length of stay as reported on the most recently filed cost report of 33.75 days, the savings to retaining the patient at the short term acute care venue would average $47,486 per Medicare patient.

3) Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: Our existing (and projected) service area is primarily Shelby County, Tennessee, plus coterminous counties in Mississippi and Arkansas. Selected JAR utilization/statistics for the first 3 LTACHS located in Shelby County (not the Applicant) are indicated in the chart below. These numbers are taken off the most recent JARs available (2015). It is important to note that Methodist Extended Care is now closed.

The Applicant (Regional MED Extended Care Hospital, LLC, d/b/a Regional One Health Extended Care Hospital, noted as "Regional Med" in the chart below) lists data for 2017, our most recent data. It is important to note that the Applicant had been staffing only 21 beds since licensure. This restriction is a reflection of the layout of our beds, and staffing the additional three (3) beds on the fourth floor originally resulted in financial loss. Therefore, the fact that we averaged 20.21 patients in a 21 bed facility is indicative of how our existing staffed beds are utilized to capacity. We now staff all 24 beds due to increased demand.

Facility	# beds	# pts	Occ Rate	Gross	Adj.	Net
Baptist	30	22.89	76.3%	$6,987.64	$5,283.73	$1,703.91
Methodist	36	31.46	87.4%	$4,023.54	$2,661.94	$1,361.60
Select Specialty	39	36.66	94.0%	$10,507.78	$7,388.76	$3,119.02
Regional MED	24	20.21	84.2%	$8,499.58	$6,683.20	$1,816.38
Total	129	111.22	86.2%			

NOTE: Gross = Gross Operating Revenue per Patient Day
Adj. = Contractual Adjustments per Patient Day
Net = Net Operating Revenue per Patient Day

Also, Methodist LTACH closed on June 20, 2016, and its license has been surrendered. In addition, Select Specialty Hospital recently (July 10, 2017) voluntarily surrendered its approved CON for 24 additional LTACH beds. As a result, sixty (60) approved LTACH beds have recently been surrendered to either the Board of Licensing Health Care Facilities or the Health Services and Development Agency.

F. 1) Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as **Attachment Section B-Economic Feasibility-F1**. **NOTE: Publicly held entities only need to reference their SEC filings.**

Response: Based on the Year 1 budget projections, and assuming the project is approved and is initiated within the timeframe as indicated, the long term acute care hospital is anticipated to realize a positive cash flow in the first year following completion of the addition. We believe the additional beds will fill up quickly, when opened.

Financials are included as Attachment B.EconomicFeasibility.F.1.

2) Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Response: Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

Year	2nd Year previous to Current Year	1st Year previous to Current Year	Current Year	Projected Year 1	Projected Year 2
Net Operating Margin Ratio	22.8%	4.9%	4.7%	12.2%	10.5%

It is common for new long term acute care hospitals to have a higher cost to charge ratio upon start-up of operations. Given that Medicare reimburses hospitals for patients who greatly exceed the anticipated length of stay (referred to as outliers) based on the cost to charge ratio, and the long term acute care hospital had a significant number of outliers which were reimbursed under this methodology, there was a larger net operating margin in our initial year of operations than in more current years.

3) Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: [Long-term debt/(Long-term debt + Total Equity (Net assets)] x 100).

Response: For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

$$\frac{\text{Long Term Debt}}{(\text{Long Term Debt} + \text{Total Equity}) \times 100} = \frac{0}{(0 + 11846000) \times 100} = 0$$

For Owner:

$$\frac{\text{Long Term Debt}}{(\text{Long Term Debt} + \text{Total Equity}) \times 100} = \frac{41,829,738}{(41,829,738 + 242,947,894) \times 100} = 0.001468 \text{ or } 14.68\%$$

G. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Response: Historical:

Payor Source	Projected Gross Operating Revenue ($)	As a % of Total
Medicare/Medicare Managed Care	41,937,308	66.9
TennCare/Medicaid	6,310,878	10.1
Commercial/Other Managed Care	12,637,108	20.2
Self-Pay	119,605	0.2
Charity Care		
Other (Specify) Worker's Compensation	1,705,005	2.7
Total	62,709,904	100.0

Project Only Projected Yr1:

Payor Source	Projected Gross Operating Revenue ($)	As a % of Total
Medicare/Medicare Managed Care	39,678,268	66.8
TennCare/Medicaid	5,975,312	10.1
Commercial/Other Managed Care	11,846,052	20.0
Self-Pay	113,244	0.2
Charity Care	151,352	0.3
Other (Specify) Worker's Compensation	1,603,772	2.6
Total	59,368,000	100.0

Total Facility Projected Yr 1:

Payor Source	Projected Gross Operating Revenue ($)	As a % of Total
Medicare/Medicare Managed Care	94,291,123	66.8
TennCare/Medicaid	14,209,583	10.1
Commercial/Other Managed Care	27,901,588	19.7
Self-Pay	269,303	0.2
Charity Care	701,615	0.5
Other (Specify) Worker's Compensation	3,756,800	2.7
Total	141,130,012	100.0

Regarding the Historical data figures given on the previous page, the issue of charity care needs to be addressed. During the 1980s, LTACHs were created to allow hospitals to discharge medically complex patients from their facilities in order to decrease Medicare spending. The long term acute care venue was designed, and is reimbursed by Medicare, to provide an appropriate venue for this acutely ill patient population, requiring an extended length of acute care stay, within the continuum of care. While adhering to the same DRG system as the short term acute care venue of care, each LTC-DRG is adjusted for the length of stay anticipated in this venue, and reimbursement based on expected resource allocation for the provision of care.

When LTACHs were first established in Tennessee, the State designed criteria and standards which included a provision that "… a minimum of 5% of the patient population using long term acute care beds will be charity or indigent care." While the long term acute care hospital intends to serve the needs of the community and the mission of the health system, the provision of charity care is a challenging prospect for a 24 bed hospital who is seeking to admit the patient population intended by Medicare to be served in this venue of care.

Additionally, the long term acute care hospital is owned by Shelby County Health Care Corporation, which as a disproportionate share hospital ("DSH"), serves a large percentage of charity care patients. As a DSH, Regional One Health is, in turn, reimbursed for the care provided to this patient population. The long term acute care hospital is not eligible for this disproportionate share allocation to serve the unfunded patient population.

The approval of this application will increase the number of LTACH beds at our facility which will serve to strengthen the financial viability, and the ability to serve the community and mission of the health system.

H. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTEs) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

Response: Please see chart below:

Position Classification	Existing FTE 30 beds	Projected FTE (54 beds Year 1)	Avg Wage $ (contractual rate)	Avg Wage $ Area/State
RN	53.3	91.3	32.71	31.75
CNA	10.1	19.9	13.23	12.95
Patient Care Extern	0.5	0.9	18.69	31.75
Dir. Respiratory Care	1.0	2.0	42.52	31.75
Liaison Nurse	2.0	4.0	34.88	31.75
Lead Respiratory Therapist	1.0	2.2	29.42	31.75
Occupational Therapist	0.8	1.6	47.67	31.75
Physical Therapist	0.9	1.8	48.18	31.75
Speech Pathologist	1.0	1.9	47.44	31.75
Patient Care Coordinator	3.5	7.4	30.35	31.75
Resp Ther/RRT	10.2	20.1	24.19	31.75
Medical Assistant	2.0	3.9	13.91	12.95
Physical Ther Asst	1.1	2.2	29.88	31.75
Resp Ther Tech/Cert	1.0	2.0	23.74	31.75
Patient Serv Clerk	5.5	11.1	14.57	12.95
a. Total Direct Care	93.8	172.3		
Nursing Clin Supv	1.0	1.0	45.67	43.95
Chief Nursing Officer	1.0	1.0	58.85	43.95
Dir HIM	1.0	1.0	37.02	43.95
Case Mgr/RN	1.1	3.0	33.97	43.95
HIM Coding Spec	0.1	0.1	22.00	12.95
Admitting Coordinator	1.0	1.0	19.85	12.95
Pre-Certification Nurse	1.9	1.9	33.65	12.95
CMS Data Coordinator	1.0	1.0	19.31	12.95
Admin Secretary	0.0	0.0	16.50	12.95
b. Total Non-Direct	8.1	10.0		
Contracted Therapy				
Contracted Med Dir/Diet.				
c. Total Contractual	0.0	0.0		
Total Staff (a + b + c)	101.9	182.3		

I. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

1) Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

Response: First, doing nothing is always an alternative, but was discarded since our high utilization and other factors indicate a need for more LTACH beds. Second, the construction of a new facility was discarded as such would be cost-prohibitive. It was felt that utilizing existing space on campus would be the most cost-efficient manner in which to provide the additional beds, plus the fastest manner in which to do so. The LTACH Moratorium, which expired in October, 2017, prevented us from adding beds in the past.

2) Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

Response: First, doing nothing is always an alternative, but was discarded since our high utilization and other factors indicate a need for more LTACH beds. Second, the construction of a new facility was discarded as such would be cost-prohibitive. It was felt that utilizing existing space on campus would be the most cost-efficient manner in which to provide the additional beds, plus the fastest manner in which to do so. The LTACH Moratorium, which expired in October, 2017, prevented us from adding beds in the past.

SECTION B: CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

A. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as, transfer agreements, contractual agreements for health services.

Response: We have a transfer agreement with Regional One Health. Our medical director and physician group agreement is with Sleep and Pulmonary Specialist, PLLC.

The average length of stay as reported on the most recently-filed cost report for our LTACH is 33.75 days.

B. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

1) Positive Effects

Response: The provision of healthcare services to patients in need normally has a positive impact on those patients, and this project is no exception. Once these beds are approved and licensed, the Applicant will be in a better position to provide needed services to patients requiring LTACH care. Further, since sixty (60) LTACH beds have been voluntarily surrendered within the past year, the addition of these requested beds will have little impact on existing providers in the area.

2) Negative Effects

Response: The Applicant is unaware of any negative impact that this project might have on the health care system. In effect, sixty (60) beds have been either voluntarily surrendered or shut down within the past year. The decrease in bed availability has increased the bed need for patients who need LTACH services.

C. 1) Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies, such as the Joint Commission and Commission on Accreditation of Rehabilitation Facilities.

Response: The Applicant hires mostly experienced staff from the local healthcare market, through formal recruitment plans and efforts as well as informal. We have a formal nurse extern program through which we have made direct hires upon successful completion. We believe that we have the clinical leadership already on staff, and adequate professional staff is available locally.

In addition, please note that the actual average hours per patient day for rehabilitation for the most recent year available is 0.4 hours (23 minutes) per patient day.

The actual average hours per patient day for nursing hours for the most recent year available (including productive time for RNs only) are 9.43 hours.

Due to the acuity of the patient population seen at Regional One Health Extended Care Hospital, the projected nurse staffing hours will be 9.48 (See calculation below) hour per patient day. The projected therapy staffing

will be .4 hours per patient day consistent with our actual in the most recent year. Combined nursing and therapy staffing hours per patient day will be 9.88.

The Applicant will continue to focus on nursing and therapeutic care for our patients, as emphasized in the guidelines for LTACH care. Furthermore, our projected caseload will require no more than three (3) hours per day of rehabilitation.

2) Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

Response: The Applicant understands these standards.

3) Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Response: The Applicant, through its Owner, has an agreement with UT Medical School to train physicians and those physicians rotate through our LTACH (Please see Attachment B.OrderlyDevelopment.C.3). In addition, we have agreements with both the University of Memphis, College of Nursing, and with Union College for the training of nursing students, and an agreement with Concord Career College for the training of Respiratory Therapy students.

D. Identify the type of licensure and certification requirements applicable and verify the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Response: Please see below:

Licensure: Tennessee Department of Health

Certification Type (e.g. Medicare SNF, Medicare LTAC, etc.): Hospital, certified in Medicare, Medicaid/TennCare patients served through various MCO contracts.

Accreditation (i.e., Joint Commission, CARF, etc.): Not Applicable

1) If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.

Response: The Applicant is an existing hospital, licensed by the Tennessee Department of Health (#36), and a copy of the license is provided as Attachment B.OrderlyDevelopment.D.1.

2) For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.

Response: The Applicant's latest survey and POC are provided as Attachment B.OrderlyDevelopment.D.2.

3) Document and explain inspections within the last three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.

   a) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

Response: Not applicable.

E. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

1) Has any of the following:

a) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);

Response: No.

b) Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or

Response: No.

c) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.

Response: No.

2) Been subjected to any of the following:

a) Final Order or Judgment in a state licensure action;

Response: No.

b) Criminal fines in cases involving a Federal or State health care offense;

Response: No.

c) Civil monetary penalties in cases involving a Federal or State health care offense;

Response: No.

d) Administrative monetary penalties in cases involving a Federal or State health care offense;

Response: No.

e) Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or

Response: No.

f) Suspension or termination of participation in Medicare or Medicaid/TennCare programs.

Response: No.

g) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.

Response: No.

h) Is presently subject to a corporate integrity agreement.

Response: No.

F. Outstanding Projects:

1) Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

Outstanding Projects					
CON Number	Project Name	Date Approved	*Annual Progress Report(s)		Expiration Date
			Due Date	Date Filed	
CN1708-025A	Reg. One Ext. Care	12/2017	01/2019	n/a	02/2021**

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

** Anticipated Expiration Date. The Applicant has not received the actual CON as of date of this filing.

2) Provide a brief description of the current progress, and status of each applicable outstanding CON.

Response: See chart above. The Applicant was recently (December, 2017 hearing) approved for the addition of 6 LTACH beds to its existing 24 bed facility (CN1708-025A). We have not received the actual printed certificate, but believe our expiration date will be January, 2021.

G. Equipment Registry – For the applicant and all entities in common ownership with the applicant.

1) Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)? _____

2) If yes, have you submitted their registration to HSDA? If you have, what was the date of submission?_____

3) If yes, have you submitted your utilization to Health Services and Development Agency? If you have, what was the date of submission? _____

Response: Not Applicable.

SECTION B: QUALITY MEASURES

Please verify that the applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

Response: The Applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

SECTION C: STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/health/topic/health-planning). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

A. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

Response: The Applicant provides inpatient long term acute care hospital (LTACH) services to an area that has recently lost many LTACH beds. An existing LTACH (Methodist Extended Care) closed and turned in its license to operate thirty-six (36) LTACH beds on June 20, 2016, and another existing LTACH (Select Specialty Hospital) turned in its approved CON to add twenty-four (24) beds on July 10, 2017. This means sixty (60) existing and/or approved LTACH beds will not be available to serve patients who need those services. This application, to add twenty-four (24) LTACH beds, is a small step in alleviating that problem, and will improve the health of the people of Tennessee who require such services.

The Applicant's goal of continuing to provide these appropriate and needed services is consistent with the State Health Plan, and this project will improve the health of Tennesseans.

B. People in Tennessee should have access to health care and the conditions to achieve optimal health.

Response: The Applicant will continue to provide a service currently needed by all citizens in the service area.

C. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

Response: The development of services by the Applicant has always been the result of attempts to meet the needs of the Tennesseans it serves. There is an unmet need for LTACH care in the service area. There currently exist only ninety-three (93) LTACH beds in the service area, plus six (6) beds approved but not in service. However, one hundred fifty-three LTACH beds have been approved for the same service area, a shortage of fifty-four (54) beds. Therefore, the approval of this application will enhance the development of more LTACH services for residents in the proposed service area.

D. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

Response: Tennessee is fortunate to have an excellent licensing division of the Department of Health. The Board of Licensing Health Care Facilities provides standards for and monitoring of licensed health care providers. This Applicant will continue to be licensed by the Department of Health and will be certified by Medicare, and Medicaid (TennCare).

E. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

Response: The Applicant is committed to providing its staff both safe working conditions and continuing education.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

Response: Proof of Publication is attached.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Note that T.C.A. §68-11-1607(c)(9)(A) states that "…Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution-based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.
Response: Not Applicable.

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

Response: The Project Completion Forecast Chart is completed.

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1 below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

Phase	Days Required	Anticipated Date [Month/Year]
1. Initial HSDA decision date		04/2018
2. Architectural and engineering contract signed		
3. Construction documents approved by the Tennessee Department of Health		
4. Construction contract signed		
5. Building permit secured		
6. Site preparation completed		
7. Building construction commenced		
8. Construction 40% complete		
9. Construction 80% complete		
10. Construction 100% complete (approved for occupancy		
11. *Issuance of License		03/2021
12. *Issuance of Service		04/2021
13. Final Architectural Certification of Payment		
14. Final Project Report Form submitted (Form HR0055)		

***For projects that *DO NOT* involve construction or renovation, complete Items 11 & 12 only.**

NOTE: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

E. Graham Baker, Jr., being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. §68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of his knowledge, information and belief.

E Graham Baker Jr
SIGNATURE/TITLE

Sworn to and subscribed before me this 11TH day of JANUARY, 2018
(Month) (Year)

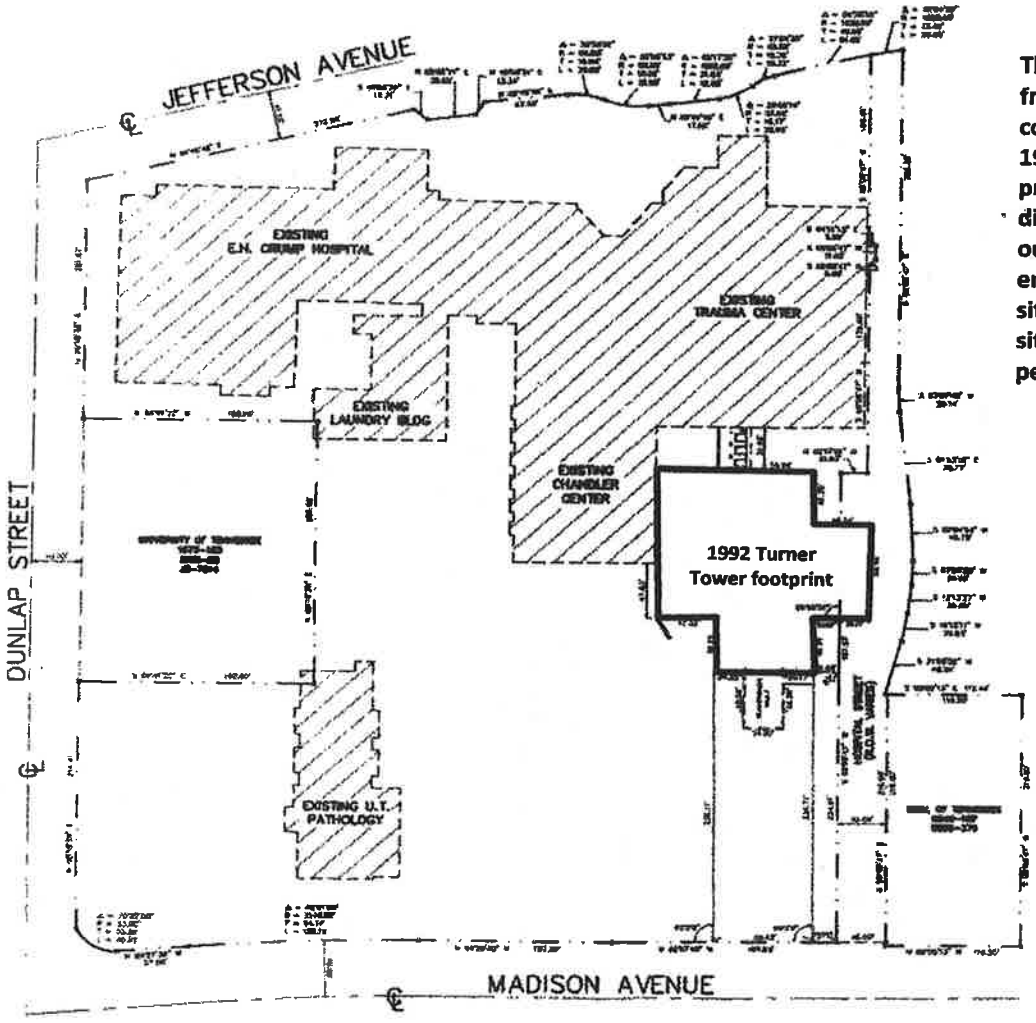
a Notary Public in and for the County/State of Davidson/Tennessee.

NOTARY PUBLIC

My commission expires 8/20 (Month/Day), 2019 (Year).

BARRY A. HICKSON JR.
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

ATTACHMENT A.6.B.1

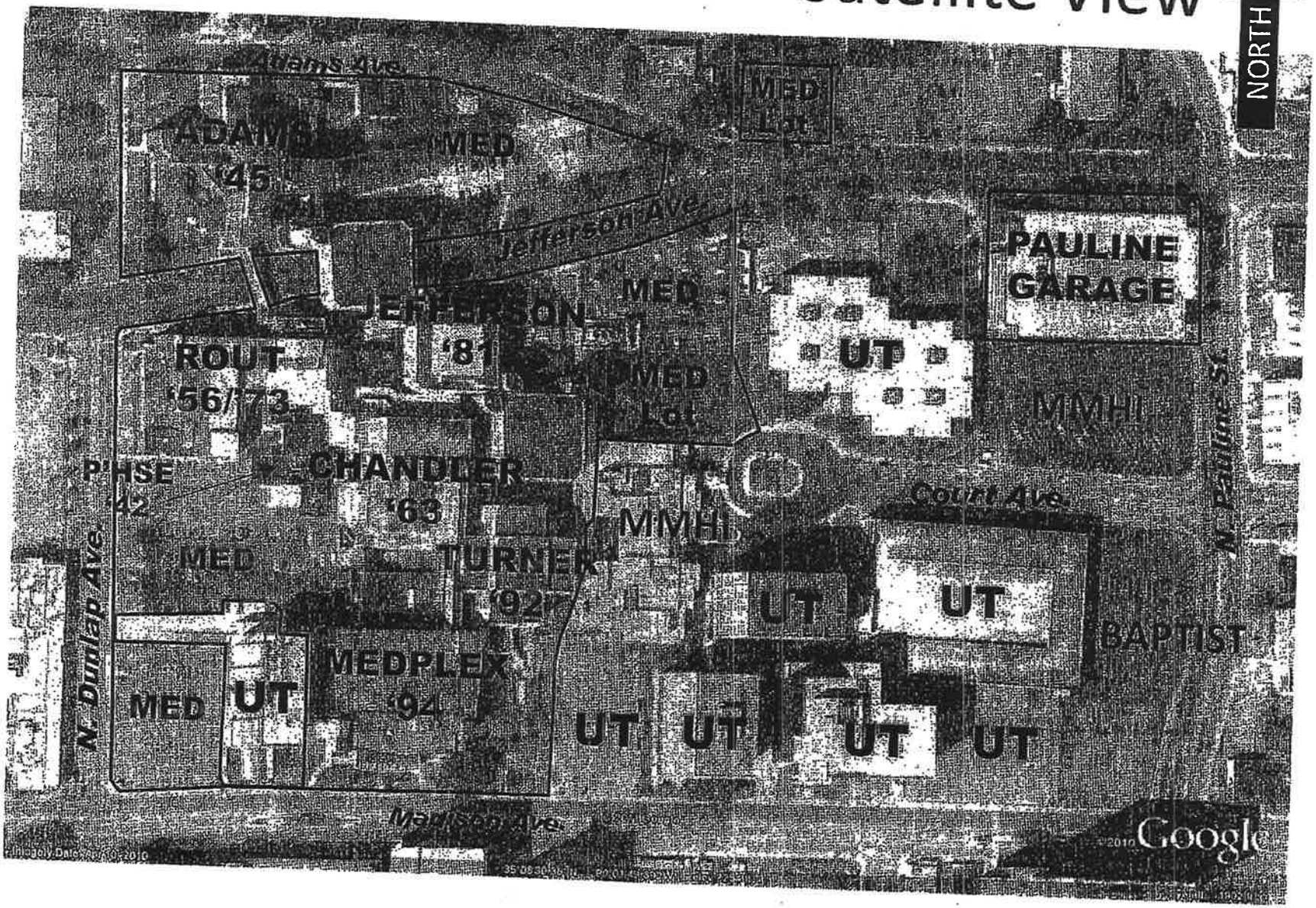


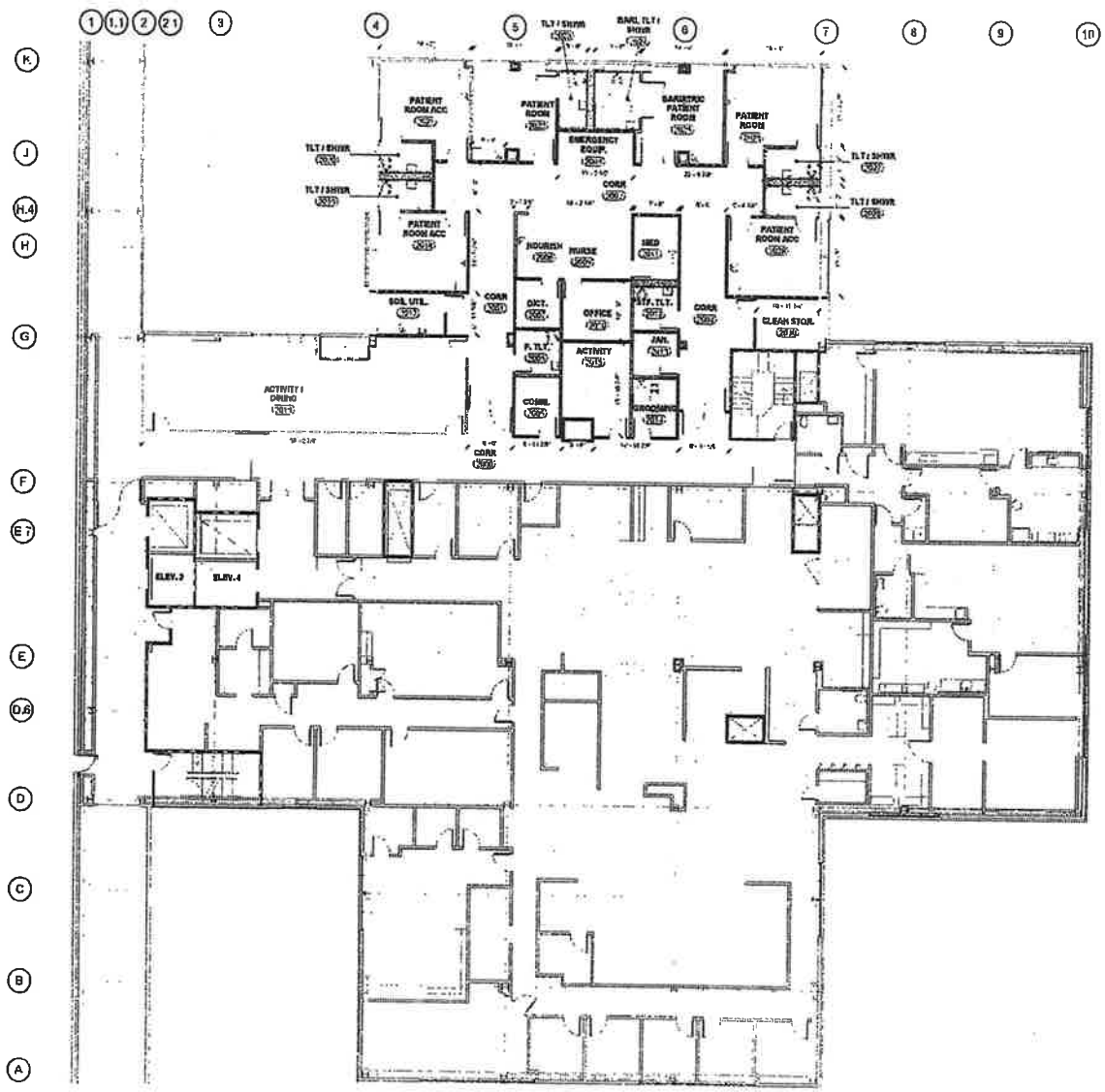
This is the original site plan from the building construction completed in 1992. The interior buildout project completed in 2014 did not include any work outside the building envelope. There was no sitework involved and no site plan was generated for permitting purposes.

18.55 ACRES ±

THE MED Regional Medical Center at Memphis +/- 18.55Acres

Satellite View





1 2ND FLOOR DIMENSION PLAN - REHAB - TURNER TOWER

ANF ARCHITECTS

APM
AMERICAN PROGRAM MANAGEMENT

WALL TYPE LEGEND

GENERAL CONSTRUCTION NOTES

KEY PLAN

DESIGN DEVELOPMENT

REGIONAL MEDICAL CENTER AT MEMPHIS

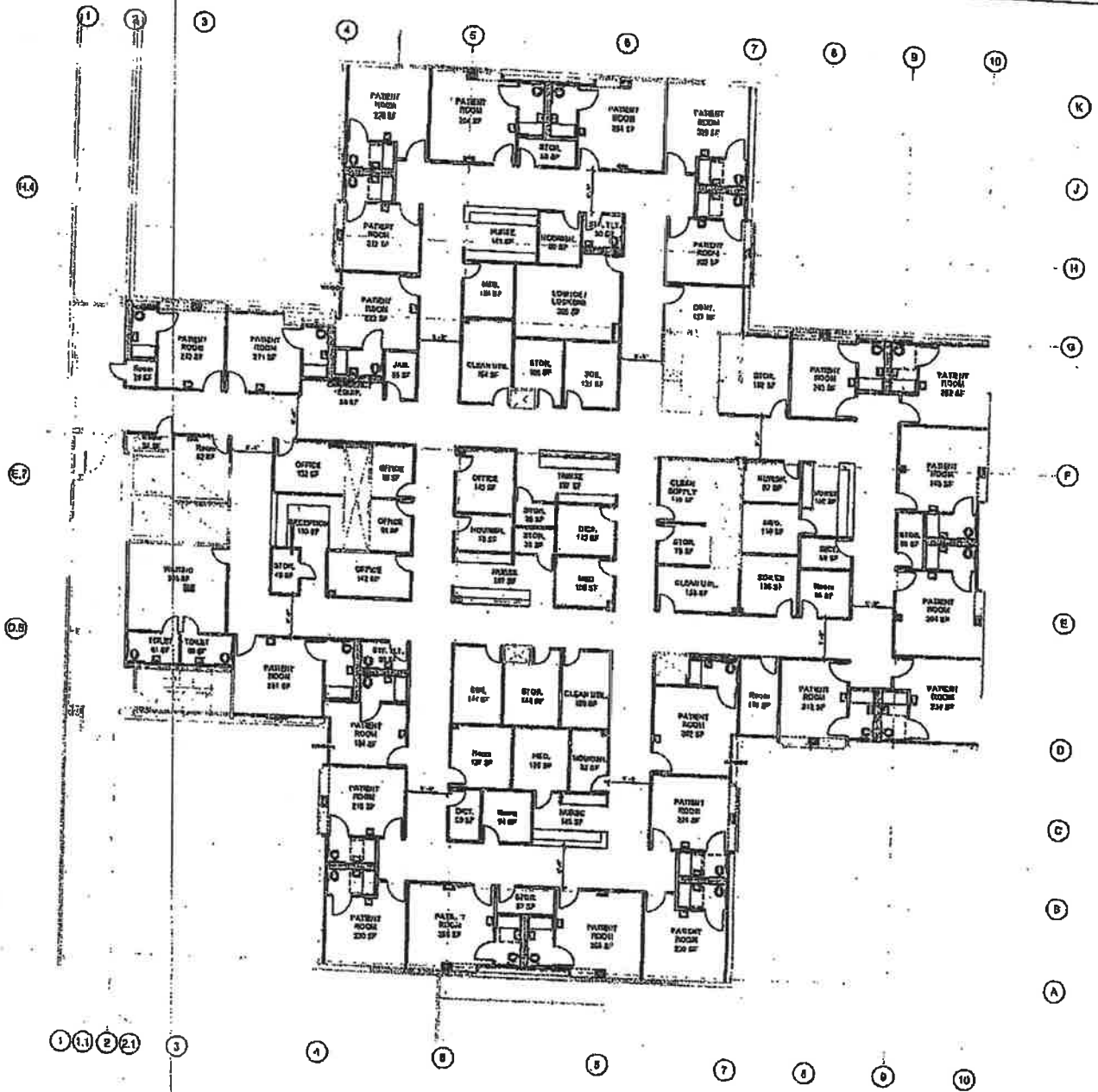
877 JEFFERSON AVE.
MEMPHIS, TN

TURNER TOWER RENOVATION

2ND FLOOR DIMENSIONAL PLAN - REHAB - TURNER TOWER

11/21/2012

A203



1 4TH FLOOR PLAN - MED SURG - TURNER TOWER
1/8"=1'-0"

KEY PLAN

SCHEMATIC DESIGN

REGIONAL MEDICAL CENTER AT MEMPHIS

TURNER TOWER RENOVATION

4TH FLOOR PLAN - MED SURG - TURNER TOWER

A205

Attachment A6.B.2

80

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services.

Response: Selected JAR utilization/statistics for the first 3 LTACHS located in Shelby County (not the Applicant) and listed in that order are indicated in the chart below. These numbers are taken off the most recent JARs available (2015).

The Applicant (Regional MED) lists data for 2017, our most recent data. It is important to note that the Applicant had been staffing only 21 beds since licensure. This restriction is a reflection of the layout of our beds, and staffing the additional three (3) beds on the fourth floor would result in financial loss. Therefore, the fact that we averaged 20.21 patients in a 21 bed facility is indicative of how our existing staffed beds are utilized to capacity (the reported 84.2% occupancy rate is based on licensed beds). Those 3 beds are now staffed.

Please see chart below:

Facility	# beds	# pts	Occ Rate	Gross	Adj.	Net
Baptist	30	22.89	76.3%	$6,987.64	$5,283.73	$1,703.91
Methodist	36	31.46	87.4%	$4,023.54	$2,661.94	$1,361.60
Select Specialty	39	36.66	94.0%	$10,507.78	$7,388.76	$3,119.02
Regional MED	24	20.21	84.2%	$8,499.58	$6,683.20	$1,816.38
Total	129	111,22	86.2%			

NOTE: Gross = Gross Operating Revenue per Patient Day
Adj. = Contractual Adjustments per Patient Day
Net = Net Operating Revenue per Patient Day

Further, the requested increase will have no impact on existing LTACH providers. If anything, it will help those providers by our having more beds for referrals from existing hospitals in Memphis. The Applicant provides inpatient long term acute care hospital (LTACH) services to an area that has recently lost many LTACH beds. Methodist LTACH closed on June 20, 2016, and its license has been surrendered. In addition, Select Specialty Hospital recently (July 10, 2017) voluntarily surrendered its approved CON for 24 additional LTACH beds. As a result, sixty (60) approved LTACH beds have recently been surrendered to either the Board of Licensing Health Care Facilities or the Health Services and Development Agency. This means sixty (60) existing and/or approved LTACH beds will not be available to serve patients who need those services. This application, to add twenty-four (24) LTACH beds, is a small step in alleviating that problem, and will improve the health of the people of Tennessee who require such services. Due to all of those beds being turned in, the addition of the few beds we request will have little impact on existing providers in the area.

LONG TERM CARE HOSPITAL BEDS

LONG TERM CARE HOSPITAL BEDS

A. Need

1. The need for long term care hospital (LTH) beds shall be determined by applying the guidelines of (0.5) beds per 10,000 population in the service area of the proposal.

The above guideline was utilized. The Applicant used the "Formula for 0.5 Long Term Care Beds per 10,000 Population by County" chart supplied by the Tennessee Department of Health, Office of Healthcare Facility Statistics.

2. If the project is a bed addition, existing long term care hospital beds must have a minimum average occupancy of 85%.

The Applicant operated at 84.2% in 2017 based on licensed beds, and 96.3% based on staffed beds.

3. The population shall be the current year's population, projected two years forward.

The above guideline was utilized. The Applicant used the "Formula for 0.5 Long Term Care Beds per 10,000 Population by County" chart supplied by the Tennessee Department of Health, Office of Healthcare Facility Statistics.

4. The primary service area can not be smaller than the applicant's Community Service Area (CSA). If LTH beds are proposed within an existing hospital, CSAs served by the existing facility can be included along with consideration for populations in adjacent states when the applicant provides documentation (such as admission sources from the Joint Annual Report).

As the service being provided is very specialized, patients originate from a wide geographic area. The facility's existing service area is primarily Shelby County, Tennessee, plus coterminous counties in Mississippi and Arkansas. A few of our patients originate in some of the western counties in Tennessee and Missouri and Alabama, but not enough to be included in the primary service area. As shown on Attachment B.Need.C, in 2015, approximately 83% of the Applicant's patients from Tennessee originated from Shelby County, approximately 53% of all patients originated from Shelby County, approximately 63% of its patients originated from Tennessee and approximately 37% of its patients came from out of state. Regarding the out of state patients, about 57% originated from Mississippi, and about 40% came from Arkansas. The approval of these relatively few beds is not expected to alter the existing service area of the Applicant.

5. Long-term care hospitals should have a minimum size of 20 beds.

The Applicant is currently licensed for 24 beds.

B. Economic Feasibility

1. The payer costs of a long-term hospital should demonstrate a substantial saving, or the services should provide additional benefit to the patient over the payer cost or over the provision of short-term general acute care alternatives, treating a similar patient mix of acuity.

LTACHs are a function of CMS. Prior to the creation of LTACHs, hospitals had to care for chronically ill patients – those requiring weeks and perhaps months of hospital stays. Based on traditional hospital reimbursement, acute care facilities lost tremendous amounts of funds caring for such individuals. This fact was recognized, and a special category of patients (long term acute care hospital patients) and resultant beds were established that received more appropriate reimbursement. This project continues that additional benefit to the patients they serve, all at a substantial savings over more traditional acute care.

2. The payer costs should be such that the facility will be financially accessible to a wide range of payers as well as to adolescent and adult patients of all ages.

This guideline is already being met, and will continue to be met.

3. Provisions will be made so that a minimum of 5% of the patient population using long term acute care beds will be charity or indigent care.

Fortunately, CMS recognizes the unique nature of these patients and provides LTACH facilities with substantial reimbursement to help cover the substantial costs incurred by the facilities. In effect, CMS tries to reimburse LTACH facilities in order to keep them in business. To that extent, most patients will qualify for some type of reimbursement. The Applicant recognizes that some patients may need charitable care, and provisions are made for such patients.

C. Orderly Development

1. Services offered by the long term care hospital must be appropriate for medically complex patients who require daily physician intervention, 24 hours access per day of professional nursing (requiring approximately 6-8 hours per patient day of nursing and therapeutic services), and on-site support and access to appropriate multi-specialty medical consultants.

Patient services should be available as needed for the most appropriate provision of care. These services should include restorative inpatient medical care, hyperalimentation, care of ventilator dependent patients, long term antibiotic therapy, long-term pain control, terminal AIDS care, and management of infectious and pulmonary diseases.

Also, to avoid unnecessary duplication, the project should not include services such as obstetrics, advanced emergency care, and other services which are not operationally pertinent to long term care hospitals.

The above guideline is met. The Applicant is a licensed LTACH, and provides appropriate long term acute care services to the patients it serves.

2. The applicant should provide assurance that the facility's patient mix will exhibit an annual average aggregate length of stay greater than 25 days as calculated by the Health Care Finance Administration (HCFA), and will seek licensure only as a hospital.

The above guideline has been met, historically, and will continue to be met.

3. The applicant should provide assurance that the projected caseload will require no more than three (3) hours per day of rehabilitation.

The above guideline has been met, historically, and will continue to be met.

4. Because of the very limited statewide need for long term hospital beds, and their high overall acuity of care, these beds should be allocated only to community service areas and be either inside or in close proximity to tertiary referral hospitals, to enhance physical accessibility to the largest concentration of services, patients, and medical specialists.

The above guideline has been met, historically, and will continue to be met. The Applicant is located inside a tertiary facility.

5. In order to insure that the beds and the facility will be used for the purpose certified, any certificate of need for a long term care hospital should be conditioned on the institution being certified by the Health Care Financing Administration as a long term care hospital, and qualifying as PPS-exempt under applicable federal guidelines. If such certification is received prior to the expiration date of the certificate of need, as provided in Tennessee Code Annotated (TCA), Section 68-11-108(c), the certificate of need shall expire, and become null and void.

The Applicant accepts this condition.

Regional One Health
EXTENDED CARE

January 11, 2018

Melanie Hill, Executive Director
Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

RE: Regional Med Extended Care Hospital, LLC d/b/a Regional One Health Extended Care Hospital

Mrs. Hill,

I am the Administrator/CEO of Regional Med Extended Care Hospital d/b/a Regional One Health Extended Care Hospital. Our latest financials, submitted with our Certificate of Need application, indicate that we have sufficient cash reserves to fund the $1,240,000 project. While the projected cost of the project exceeds $8 million, the remainder will be provided for under a lease arrangement.

This is to notify you that our cash reserves are available for this project. Please do not hesitate to contact me with any questions at (901) 515-3030 or via email at mkelly@regionalonehealth.org.

Sincerely,

Mark A. Kelly
Administrator and CEO

Formula for 0.5 Long Term Care Beds per 10,000 Population by County

Anderson	4	4
Bedford	3	3
Benton	1	1
Bledsoe	1	1
Blount	7	7
Bradley	5	5
Campbell	2	2
Cannon	1	1
Carroll	1	1
Carter	3	3
Cheatham	2	2
Chester	1	1
Claiborne	2	2
Clay	0	0
Cocke	2	2
Coffee	3	3
Crockett	1	1
Cumberland	3	3
Davidson	34	35
Decatur	1	1
DeKalb	1	1
Dickson	3	3
Dyer	2	2
Fayette	2	2
Fentress	1	1
Franklin	2	2
Gibson	3	3
Giles	2	2
Grainger	1	1
Greene	4	4
Grundy	1	1
Hamblen	3	3
Hamilton	18	18
Hancock	0	0
Hardeman	1	1
Hardin	1	1
Hawkins	3	3
Haywood	1	1
Henderson	1	2
Henry	2	2
Hickman	1	1
Houston	0	0
Humphreys	1	1
Jackson	1	1
Jefferson	3	3
Johnson	1	1
Knox	24	24
Lake	0	0
Lauderdale	1	1
Lawrence	2	2
Lewis	1	1
Lincoln	2	2
Loudon	3	3
McMinn	3	3
McNairy	1	1
Macon	1	1
Madison	5	5
Marion	1	1
Marshall	2	2
Maury	4	5
Meigs	1	1
Monroe	2	2
Montgomery	10	11
Moore	0	0
Morgan	1	1
Obion	2	2
Overton	1	1
Perry	0	0
Pickett	0	0
Polk	1	1
Putnam	4	4
Rhea	2	2
Roane	3	3
Robertson	4	4
Rutherford	16	17
Scott	1	1
Sequatchie	1	1
Sevier	5	5
Shelby	48	49
Smith	1	1
Stewart	1	1
Sullivan	8	8
Sumner	9	9
Tipton	3	4
Trousdale	0	0
Unicoi	1	1
Union	1	1
Van Buren	0	0
Warren	2	2
Washington	7	7
Wayne	1	1
Weakley	2	2
White	1	1
Williamson	11	12
Wilson	7	7

Population Data: The University of Tennessee Center for Business and Economic Research Population Projection Data Files (2017 Revision, 5/17), Reassembled by the Tennessee Department of Health, Division of Policy, Planning and Assessment.
Note: These data will not match the University of Tennessee Data exactly due to rounding.

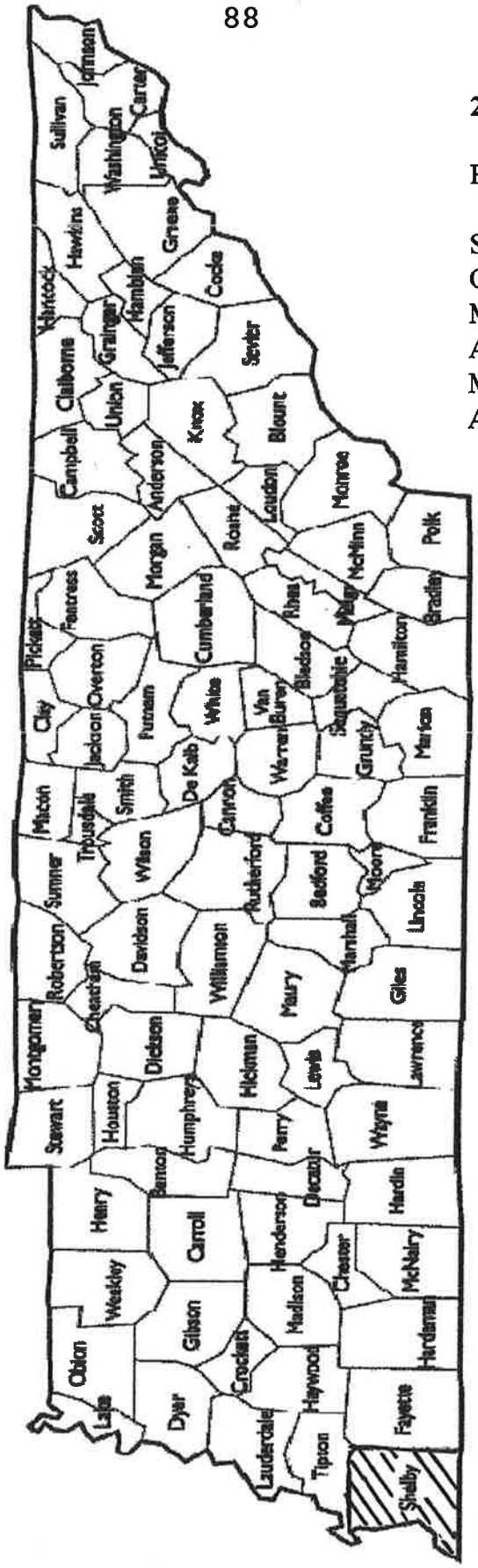
Source: Tennessee Department of Health, Office of Healthcare Facility Statistics.

2015 JAR:

Patient Origin:

Shelby County	95
Other TN Counties	19
Mississippi	38
Arkansas	27
Missouri	1
Alabama	1
Total	181

County Level Map



United States Census Bureau

QuickFacts

selected: Shelby County, Tennessee; UNITED STATES

QuickFacts provides statistics for all states and counties, and for cities and towns with a ***population of 5,000 or more.***

able

All Topics	Shelby County, Tennessee	UNITED STATES
Population per square mile, 2010	1,215.5	87.4
PEOPLE		
Population		
Population estimates, July 1, 2016, (V2016)	934,603	323,127,513
Population estimates base, April 1, 2010, (V2016)	927,684	308,758,105
Population, percent change - April 1, 2010 (estimates base) to July 1, 2016, (V2016)	0.7%	4.7%
Population, Census, April 1, 2010	927,644	308,745,538
Age and Sex		
Persons under 5 years, percent, July 1, 2016, (V2016)	7.2%	6.2%
Persons under 5 years, percent, April 1, 2010	7.2%	6.5%
Persons under 18 years, percent, July 1, 2016, (V2016)	25.2%	22.8%
Persons under 18 years, percent, April 1, 2010	26.4%	24.0%
Persons 65 years and over, percent, July 1, 2016, (V2016)	12.5%	15.2%
Persons 65 years and over, percent, April 1, 2010	10.3%	13.0%
Female persons, percent, July 1, 2016, (V2016)	52.4%	50.8%
Female persons, percent, April 1, 2010	52.3%	50.8%
Race and Hispanic Origin		
White alone, percent, July 1, 2016, (V2016) (a)	41.4%	76.9%
White alone, percent, April 1, 2010 (a)	40.6%	72.4%
Black or African American alone, percent, July 1, 2016, (V2016) (a)	54.1%	13.3%
Black or African American alone, percent, April 1, 2010 (a)	52.1%	12.6%
American Indian and Alaska Native alone, percent, July 1, 2016, (V2016) (a)	0.4%	1.3%
American Indian and Alaska Native alone, percent, April 1, 2010 (a)	0.2%	0.9%
Asian alone, percent, July 1, 2016, (V2016) (a)	2.6%	5.7%
Asian alone, percent, April 1, 2010 (a)	2.3%	4.8%
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2016, (V2016) (a)	0.1%	0.2%
Native Hawaiian and Other Pacific Islander alone, percent, April 1, 2010 (a)	Z	0.2%
Two or More Races, percent, July 1, 2016, (V2016)	1.5%	2.6%
Two or More Races, percent, April 1, 2010	1.4%	2.9%
Hispanic or Latino, percent, July 1, 2016, (V2016) (b)	6.1%	17.8%
Hispanic or Latino, percent, April 1, 2010 (b)	5.6%	16.3%
White alone, not Hispanic or Latino, percent, July 1, 2016, (V2016)	36.2%	61.3%
White alone, not Hispanic or Latino, percent, April 1, 2010	38.7%	63.7%
Population Characteristics		
Veterans, 2011-2015	54,847	20,108,332
Foreign born persons, percent, 2011-2015	6.2%	13.2%
Housing		
Housing units, July 1, 2016, (V2016)	406,022	135,697,926
Housing units, April 1, 2010	398,274	131,704,730
Owner-occupied housing unit rate, 2011-2015	57.3%	63.9%
Median value of owner-occupied housing units, 2011-2015	$130,800	$178,600
Median selected monthly owner costs -with a mortgage, 2011-2015	$1,352	$1,492
Median selected monthly owner costs -without a mortgage, 2011-2015	$479	$458
Median gross rent, 2011-2015	$859	$928
Building permits, 2016	2,338	1,206,642
Families & Living Arrangements		
Households, 2011-2015	347,224	116,926,305
Persons per household, 2011-2015	2.65	2.64
Living in same house 1 year ago, percent of persons age 1 year+, 2011-2015	83.1%	85.1%

Language other than English spoken at home, percent of persons age 5 years+, 2011-2015	9.4%	21.0%
Education		
High school graduate or higher, percent of persons age 25 years+, 2011-2015	86.9%	86.7%
Bachelor's degree or higher, percent of persons age 25 years+, 2011-2015	30.2%	29.8%
Health		
With a disability, under age 65 years, percent, 2011-2015	9.3%	8.6%
Persons without health insurance, under age 65 years, percent	▲ 13.6%	▲ 10.5%
Economy		
In civilian labor force, total, percent of population age 16 years+, 2011-2015	65.4%	63.3%
In civilian labor force, female, percent of population age 16 years+, 2011-2015	62.0%	58.5%
Total accommodation and food services sales, 2012 ($1,000) (c)	1,889,742	708,138,598
Total health care and social assistance receipts/revenue, 2012 ($1,000) (c)	8,166,690	2,040,441,203
Total manufacturers shipments, 2012 ($1,000) (c)	22,412,702	5,696,729,632
Total merchant wholesaler sales, 2012 ($1,000) (c)	35,454,262	5,208,023,478
Total retail sales, 2012 ($1,000) (c)	22,058,481	4,219,821,871
Total retail sales per capita, 2012 (c)	$23,447	$13,443
Transportation		
Mean travel time to work (minutes), workers age 16 years+, 2011-2015	22.6	25.9
Income & Poverty		
Median household income (in 2015 dollars), 2011-2015	$46,224	$53,889
Per capita income in past 12 months (in 2015 dollars), 2011-2015	$26,285	$28,930
Persons in poverty, percent	▲ 20.2%	▲ 13.5%

BUSINESSES

Businesses		
Total employer establishments, 2015	19,311	7,663,938
Total employment, 2015	430,779	124,065,947
Total annual payroll, 2015 ($1,000)	21,121,882	6,253,488,252
Total employment, percent change, 2014-2015	1.0%	2.5%
Total nonemployer establishments, 2015	78,921	24,331,403
All firms, 2012	95,433	27,626,360
Men-owned firms, 2012	43,633	14,844,597
Women-owned firms, 2012	45,031	9,878,397
Minority-owned firms, 2012	52,295	7,952,386
Nonminority-owned firms, 2012	40,569	18,987,918
Veteran-owned firms, 2012	9,486	2,521,682
Nonveteran-owned firms, 2012	82,645	24,070,685

GEOGRAPHY

Geography		
Population per square mile, 2010	**1,215.5**	**87.4**
Land area in square miles, 2010	763.17	3,531,905.43
FIPS Code	47157	00

Value Notes

▲ This geographic level of poverty and health estimates are not comparable to other geographic levels of these estimates

Some estimates presented here come from sample data, and thus have sampling errors that may render some apparent differences between geographies statistically indistinguishable. Click the Quick left of each row in TABLE view to learn about sampling error.

The vintage year (e.g., V2016) refers to the final year of the series (2010 thru 2016). *Different vintage years of estimates are not comparable.*

Fact Notes

- **(a)** Includes persons reporting only one race
- **(b)** Hispanics may be of any race, so also are included in applicable race categories
- **(c)** Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

Value Flags

- **D** Suppressed to avoid disclosure of confidential information
- **F** Fewer than 25 firms
- **FN** Footnote on this item in place of data
- **NA** Not available
- **S** Suppressed; does not meet publication standards
- **X** Not applicable
- **Z** Value greater than zero but less than half unit of measure shown
- **-** Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lo interval of an open ended distribution.

QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area SHealth Insurance Estimates, Small A Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits.

Health Resources & Services Administration
HRSA Data Warehouse

Topic Areas | Tools | Data | FAQs & Resources | About HDW | HRSA.gov

Home > Tools > Analyzers > MUA Find > MUA Find Results

MUA Find Results

Search Criteria

Click on a column heading to sort the results in ascending or descending order.

Start Over | Modify Search Criteria | Map View

Data as of 8/10/2017

State: Tennessee
County: Shelby County
MUA ID: All

Collapse All

1 Page Size: 20

04 items in 01 pa

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Population Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Da
Shelby County	157	Shelby Service Area	03249	Medically Underserved Area	Medically Underserved Area	56.50	07/12/1994	07/12/1994
CT 0201.01 CT 0201.02 CT 0202.10 CT 0205.12								
Shelby County	157	Shelby Service Area	03250	Medically Underserved Area	Medically Underserved Area	51.00	07/12/1994	07/12/1994
CT 0216.20 CT 0219.00 CT 0220.22 CT 0220.23 CT 0220.24 CT 0221.11 CT 0221.12 CT 0222.10 CT 0222.20 CT 0223.10 CT 0223.21 CT 0223.30 CT 0224.10 CT 0225.00 CT 0227.00								
Shelby County	157	Nw Memphis Service Area	07469	Medically Underserved Area	Medically Underserved Area	56.00	04/06/2005	04/06/2005

1 Page Size: 20 04 items in 01 pa

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Population Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Da
Shelby County	157	Southeast Memphis	07971	Medically Underserved Area	Medically Underserved Area	58.10	07/31/2014	07/31/2014

CT 0002.00
CT 0003.00
CT 0004.00
CT 0006.00
CT 0007.00
CT 0008.00
CT 0009.00
CT 0011.00
CT 0012.00
CT 0013.00
CT 0014.00
CT 0015.00
CT 0017.00
CT 0019.00
CT 0020.00
CT 0021.00
CT 0024.00
CT 0025.00
CT 0027.00
CT 0028.00
CT 0030.00
CT 0036.00
CT 0089.00
CT 0099.01
CT 0099.02
CT 0100.00
CT 0101.10
CT 0101.20
CT 0102.10
CT 0102.20
CT 0103.00
CT 0111.00
CT 0112.00
CT 0113.00
CT 0205.21
CT 0205.23
CT 0205.24

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1 Page Size: 20 04 items in 01 pa

County Name	County FIPS Code	Service Area Name	MUA/P Source Identification Number	Designation Type	Population Type	Index of Medical Underservice Score	MUA/P Designation Date	MUA/P Update Da
CT 0081.10								
CT 0081.20								
CT 0082.00								
CT 0097.00								
CT 0105.00								
CT 0106.10								
CT 0106.20								
CT 0106.30								
CT 0107.10								
CT 0107.20								
CT 0108.10								
CT 0108.20								
CT 0110.10								
CT 0110.20								
CT 0118.00								
CT 0217.10								
CT 0217.21								
CT 0217.24								
CT 0217.25								
CT 0217.26								
CT 0217.31								
CT 0217.32								
CT 0217.41								
CT 0217.44								
CT 0217.45								
CT 0217.46								
CT 0217.47								
CT 0217.51								
CT 0217.52								
CT 0217.53								
CT 0217.54								
CT 0226.00								
CT 9801.00								

1 Page Size: 20 04 items in 01 pa

Health & Human Services

HRSA Health Resources & Services Administration Data Warehouse

HPSA Find Results

Search Criteria

Start Over | Modify Search Criteria | Map View

Click on a column heading to sort the results in ascending or descending order.

Data as of 8/10/2017

State: Tennessee
County: Shelby County
Discipline: Primary Care
Metro: All
Status: D,P
Type: All
Date of Last Update: All Dates
HPSA Score: From 0 To 26

Collapse All

1 Page Size: 20 07 items in 01 pa

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	Population Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Shelby County	157	1479994793	Christ Community Health Services, Inc.	Primary Care	Comprehensive Health Center			18	Designated	01/14/2013
Shelby County	157	1479994795	Memphis Health Center, Inc.	Primary Care	Comprehensive Health Center			17	Designated	11/04/2010
Shelby County	157	1477429209	Federal Correctional Institution - Memphis	Primary Care	Correctional Facility		0	12	Designated	12/30/2015
Shelby County	157	1479994706	Low Income - Frayser/ Raleigh	Primary Care	HPSA Population	Low Income Population on HPSA	31	10	Designated	12/04/2013

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Shelby County	157		100	Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157		101.10	Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157		101.20	Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157		102.10	Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157		102.20	Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157		103	Primary Care	Census Tract			Designated	12/04/2013

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
1 Page Size: 20									07 items in 01 pa
Shelby County	157	11		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	111		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	112		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	113		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	12		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	13		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	14		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	15		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	17		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	19		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	2		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	20		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	205.11		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	205.12		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	205.21		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	205.23		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	205.24		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	205.31		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	205.32		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	205.41		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	205.42		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	206.21		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	206.44		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	206.51		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	21		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	24		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	25		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	27		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	28		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	3		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	30		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	36		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	4		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	6		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	7		Primary Care	Census Tract			Designated	12/04/2013

HPSA Find Results

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Updated Date
1 Page Size: 20									07 items in 01 pa
Shelby County	157	8		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	89		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	9		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	99.01		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	99.02		Primary Care	Census Tract			Designated	12/04/2013
Shelby County	157	1479994707	Low Income - Southwest Memphis	Primary Care	HPSA Population	Low Income Population on HPSA	37	16	Designated	06/03/2014

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Updated Date
Shelby County	157		105	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		106.10	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		106.20	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		106.30	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		108.10	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		110.10	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		110.20	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		114	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		115	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		116	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		117	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		118	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		217.31	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		219	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		220.22	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		220.23	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		220.24	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		221.11	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		221.12	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		221.21	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		221.22	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		221.30	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		222.10	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		222.20	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		223.10	Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157		223.21	Primary Care	Census Tract			Designated	06/03/2014

HPSA Find Results

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Updated Date
1	Page Size: 20								
Shelby County	157	223.22		Primary Care	Census Tract			Designated	06/03/2014
County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	Population Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Shelby County	157	223.30		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	224.10		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	225		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	226		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	227		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	37		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	38		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	39		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	45		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	46		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	50		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	53		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	55		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	56		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	57		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	58		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	59		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	60		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	62		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	63		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	64		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	65		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	66		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	67		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	68		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	69		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	70		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	73		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	74		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	75		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	78.10		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	78.21		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	78.22		Primary Care	Census Tract				Designated	06/03/2014
Shelby County	157	79		Primary Care	Census Tract				Designated	06/03/2014

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
1	Page Size: 20								07 items in 01 pa
Shelby County	157	80		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	81.10		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	81.20		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	82		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	9801		Primary Care	Census Tract			Designated	06/03/2014
Shelby County	157	147999470A	Low Income - Parkway Village/Fox Meadows	Primary Care	HPSA Population	Low Income Population on HPSA	3	12	Designated	01/31/2014

County Name	County FIPS Code	HPSA ID	HPSA Name	HPSA Discipline Class	Designation Type	HPSA FTE	HPSA Score	HPSA Status	HPSA Designation Last Update Date
Shelby County	157		107.10	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		107.20	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		108.20	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.10	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.21	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.24	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.25	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.26	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.32	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.41	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.44	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.45	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.46	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.47	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.51	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.52	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.53	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157		217.54	Primary Care	Census Tract			Designated	01/31/2014
Shelby County	157	1479994700	Tri State Community Health Center	Primary Care	Comprehensive Health Center		22	Designated	07/31/2017

1 Page Size: 20 07 items in 01 pa

Note: Satellite sites of Comprehensive Health Centers automatically assume the HPSA score of the affiliated grantee -- they are not listed separately.

APM
AMERICAN PROGRAM MANAGEMENT

January 11, 2018

J. Richard Wagers, Jr.
Regional One Health
877 Jefferson Avenue
Memphis, TN 38103

Dear Mr. Wagers,

As Project Manager for the Regional Med Extended Care Hospital in Memphis, I have reviewed the construction costs for this project, and believe that $1,240,000 is a sufficient estimate to complete this 24 bed project. Further, to the best of our knowledge, the project provides a physical environment compliant with all applicable federal, state and local construction codes, standards, specifications, and requirements, and the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the *2014 Guidelines for Design and Construction of Hospitals and Outpatient Facilities*.

Sincerely,

Warren N. Goodwin

Warren N. Goodwin, FAIA
President & CEO

Cc: Graham Baker
Ken Goff

Regional One Health
EXTENDED CARE

January 11, 2018

Melanie Hill, Executive Director
Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

RE: Regional Med Extended Care Hospital, LLC d/b/a Regional One Health Extended Care Hospital

Mrs. Hill,

I am the Administrator/CEO of Regional Med Extended Care Hospital d/b/a Regional One Health Extended Care Hospital. Our latest financials, submitted with our Certificate of Need application, indicate that we have sufficient cash reserves to fund the $1,240,000 project. While the projected cost of the project exceeds $8 million, the remainder will be provided for under a lease arrangement.

This is to notify you that our cash reserves are available for this project. Please do not hesitate to contact me with any questions at (901) 515-3030 or via email at mkelly@regionalonehealth.org.

Sincerely,

Mark A. Kelly
Administrator and CEO

KPMG

SHELBY COUNTY HEALTH CARE CORPORATION

(A Component Unit of Shelby County, Tennessee)

Basic Financial Statements and Schedules

June 30, 2016 and 2015

(With Independent Auditors' Report Thereon)

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Table of Contents

KPMG LLP
Triad Centre III
Suite 450
6070 Poplar Avenue
Memphis, TN 38119-3901

Independent Auditors' Report

The Board of Directors
Shelby County Health Care Corporation:

We have audited the accompanying statements of net position and statements of revenues, expenses, and changes in net position and cash flows of Shelby County Health Care Corporation, a component unit of Shelby County, Tennessee (d/b/a Regional One Health) as of and for the years ended June 30, 2016 and 2015, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective net position of Shelby County Health Care Corporation as of June 30, 2016 and 2015, and the respective changes in net position and cash flows for the years then ended, in accordance with U.S. generally accepted accounting principles.

KPMG

Other Matters

Our audit was conducted for the purpose of forming an opinion on the financial statements that collectively comprise Shelby County Health Care Corporation's basic financial statements. The supplementary information included in schedules 1, 2, 3, 4, 5, 6, and 7 is presented for the purpose of additional analysis and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information, except for the portion marked "unaudited," on which we express no opinion, has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the basic financial statements as a whole.

Management has omitted management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November 11, 2016, on our consideration of Shelby County Health Care Corporation's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Shelby County Health Care Corporation's internal control over financial reporting and compliance.

KPMG LLP

Memphis, Tennessee
November 11, 2016

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Statements of Net Position

June 30, 2016 and 2015

Assets	2016	2015
Assets:		
Cash and cash equivalents	$ 16,710,050	9,764,159
Investments	111,841,180	109,959,639
Patient accounts receivable, net of allowances for uncollectible accounts of $130,031,000 in 2016 and $169,265,000 in 2015	64,422,437	68,627,756
Other receivables	13,811,415	10,968,415
Other current assets	7,282,171	7,035,719
Total current assets	214,067,253	206,355,688
Restricted cash	437,060	514,785
Restricted investments	6,062,721	6,901,313
Equity investments	12,980,671	10,999,876
Notes receivable	19,221,600	19,221,600
Capital assets, net	90,988,913	96,007,465
Total assets	$ 343,758,218	340,000,727
Liabilities and Net Position		
Liabilities:		
Accounts payable	$ 14,452,736	14,092,765
Accrued expenses and other current liabilities	44,527,850	38,317,676
Total current liabilities	58,980,586	52,410,441
Accrued professional and general liability costs	2,426,000	4,530,000
Obligation under reverse repurchase agreement	11,893,738	—
Net postemployment benefit obligation	960,000	750,000
Notes payable	26,550,000	26,550,000
Total liabilities	100,810,324	84,240,441
Net position:		
Net investment in capital assets	64,438,913	69,457,465
Restricted for:		
Capital assets	1,896,509	2,855,282
Indigent care	702,167	834,684
Notes payable	437,060	514,785
Unrestricted	175,473,245	182,098,070
Total net position	242,947,894	255,760,286
Total liabilities and net position	$ 343,758,218	340,000,727

See accompanying notes to basic financial statements.

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Statements of Revenues, Expenses, and Changes in Net Position

Years ended June 30, 2016 and 2015

	2016	2015
Operating revenues:		
Net patient service revenue (including additional incremental reimbursement from various state agencies for participation in TennCare/Medicaid programs of approximately $74,008,000 in 2016 and $67,387,000 in 2015)	$ 362,356,166	347,134,962
Other revenue	33,331,773	26,239,916
Total operating revenues	395,687,939	373,374,878
Operating expenses:		
Salaries and benefits	191,513,277	179,221,725
Supplies and services	93,353,541	84,128,275
Physician and professional fees	26,080,862	25,475,185
Purchased medical services	56,015,982	44,448,420
Plant operations	14,630,265	13,783,854
Insurance	422,542	2,843,248
Administrative and general	38,928,298	34,746,038
Community services	933,161	757,581
Depreciation	18,571,929	18,204,987
Total operating expenses	440,449,857	403,609,313
Operating loss	(44,761,918)	(30,234,435)
Nonoperating revenues (expenses):		
Interest expense	(397,898)	(347,791)
Investment income	3,066,749	3,578,035
Appropriations from Shelby County	27,408,000	26,816,000
Other	1,872,675	8,730,159
Total nonoperating revenues, net	31,949,526	38,776,403
Increase (decrease) in net position	(12,812,392)	8,541,968
Net position, beginning of year	255,760,286	247,218,318
Net position, end of year	$ 242,947,894	255,760,286

See accompanying notes to basic financial statements.

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Statements of Cash Flows

Years ended June 30, 2016 and 2015

	2016	2015
Cash flows from operating activities:		
Receipts from and on behalf of patients and third-party payors	$ 367,284,642	335,009,290
Other cash receipts	33,212,527	25,607,911
Payments to suppliers	(232,319,636)	(208,312,598)
Payments to employees and related benefits	(186,503,501)	(180,016,276)
Net cash used in operating activities	(18,325,968)	(27,711,673)
Cash flows from noncapital financing activity:		
Appropriations received from Shelby County	25,328,013	26,816,000
Net cash provided by noncapital financing activity	25,328,013	26,816,000
Cash flows from capital and related financing activities:		
Capital expenditures	(13,661,497)	(11,893,966)
Proceeds from pledges	—	22,169
Proceeds from sale of capital assets	—	31,398
Interest payments	(389,920)	(351,916)
Net cash used in capital and related financing activities	(14,051,417)	(12,192,315)
Cash flows from investing activities:		
Purchases of investments	(300,665,214)	(238,329,755)
Proceeds from sale of investments	312,242,913	249,085,424
Investment in equity investees	—	(1,300,000)
Investment income proceeds	2,339,839	3,345,720
Net cash provided by investing activities	13,917,538	12,801,389
Net increase (decrease) in cash and cash equivalents	6,868,166	(286,599)
Cash and cash equivalents, beginning of year	10,278,944	10,565,543
Cash and cash equivalents, end of year	$ 17,147,110	10,278,944

(Continued)

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Statements of Cash Flows

Years ended June 30, 2016 and 2015

	2016	2015
Reconciliation of operating loss to net cash used in operating activities:		
Operating loss	$ (44,761,918)	(30,234,435)
Adjustment to reconcile operating loss to net cash used in operating activities:		
Depreciation	18,571,929	18,204,987
Changes in operating assets and liabilities:		
Patients accounts receivable, net	4,205,319	(20,725,209)
Other receivables	(763,013)	937,865
Other current assets	(246,452)	(786,317)
Accounts payable	359,971	6,069,016
Accrued expenses and other current liabilities	6,202,196	(855,580)
Accrued professional and general liability costs	(2,104,000)	(322,000)
Net postemployment benefit obligation	210,000	—
Net cash used in operating activities	$ (18,325,968)	(27,711,673)
Reconciliation of cash and cash equivalents to the statements of net position:		
Cash and cash equivalents in current assets	$ 16,710,050	9,764,159
Cash and cash equivalents held for payment of outstanding debt fees	437,060	514,785
Total cash and cash equivalents	$ 17,147,110	10,278,944
Supplemental schedule of noncash investing and financing activities:		
Net decrease in the fair value of investments	$ (619,180)	(347,515)
Equity in net income of equity investees	1,980,795	8,707,269
(Loss) gain on capital asset disposals	(108,121)	721

See accompanying notes to basic financial statements.

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)
Notes to Basic Financial Statements
June 30, 2016 and 2015

(1) Organization and Summary of Significant Accounting Policies

Shelby County Health Care Corporation (d/b/a Regional One Health) was incorporated on June 15, 1981, with the approval of the Board of County Commissioners of Shelby County, Tennessee (the County). Regional One Health is a broad continuum healthcare provider that operates facilities owned by the County under a long-term lease. The lease arrangement effectively provided for the transfer of title associated with operating fixed assets and the long-term lease (for a nominal amount) of related real property. The lease expires in 2063.

Regional One Health is a component unit of the County as defined by Governmental Accounting Standards Board (GASB) Statement No. 61, *The Financial Reporting Entity: Omnibus – an amendment of GASB Statement No. 14 and No. 34*. Regional One Health's component unit relationship to the County is principally due to financial accountability and financial benefit or burden as defined in GASB Statement No. 61. Regional One Health is operated by a 15-member board of directors, all of whom are appointed by the Mayor of the County and approved by the County Commission.

Regional One Health Foundation is a component unit of Regional One Health principally due to Regional One Health's financial accountability and financial benefit or burden for Regional One Health Foundation as defined in GASB Statement No. 61. Regional One Health Foundation is operated by a board of directors, all of whom are appointed by Regional One Health's board. Regional One Health Foundation is a blended component unit of Regional One Health because it provides services entirely to Regional One Health. Regional One Health Foundation issues separate audited financial statements, which can be obtained by writing to Regional Medical Center Foundation, 877 Jefferson Avenue, Memphis, Tennessee 38103 or by calling 901-545-7482.

GASB Statement No. 34, *Basic Financial Statements – and Management's Discussion and Analysis – for State and Local Governments*, requires a management's discussion and analysis (MD&A) section providing an analysis of Regional One Health's overall financial position and results of operations; however, Regional One Health has chosen to omit the MD&A from these accompanying financial statements.

The significant accounting policies used by Regional One Health in preparing and presenting its financial statements follow:

(a) Presentation

The financial statements include the accounts of Regional One Health and its wholly owned subsidiaries. Such subsidiaries include Regional One Properties, Inc., Regional Med Extended Care Hospital, LLC, and Shelby County Health Care Properties, Inc. All material intercompany accounts and transactions have been eliminated.

(b) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires that management make estimates and assumptions affecting the reported amounts of assets, liabilities, revenues, and expenses, as well as disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

(Continued)

Significant items subject to estimates and assumptions include the determination of the allowances for contractual adjustments and uncollectible accounts, reserves for professional and general liability claims, reserves for employee healthcare claims, net postretirement benefit cost and obligation, and estimated third-party payor settlements.

In addition, laws and regulations governing Medicare, TennCare, and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates related to these programs will change by a material amount in the near term.

(c) Enterprise Fund Accounting

Regional One Health's financial statements are prepared using the economic resources measurement focus and accrual basis of accounting.

(d) Cash Equivalents

Regional One Health considers investments in highly liquid debt instruments purchased with an original maturity of three months or less to be cash equivalents.

(e) Investments and Investment Income

Investments are carried at fair value, principally based on quoted market prices. Investment income (including realized and unrealized gains and losses) from investments is reported as nonoperating revenue.

(f) Inventories

Inventories, consisting principally of medical supplies and pharmaceuticals, are stated at the lower of cost (first-in, first-out method) or replacement market.

(g) Equity Investments

Equity investments consist of Regional One Health's equity interests in investments as measured by its ownership interest if Regional One Health has an ongoing financial interest in or ongoing financial responsibility for the equity investee. The investments are initially recorded at cost and are subsequently adjusted for additional contributions, distributions, undistributed earnings and losses, and impairment losses.

(h) Capital Assets

Capital assets are recorded at cost, if purchased, or at fair value at the date of donation. Depreciation is provided over the useful life of each class of depreciable asset using the straight-line method. Maintenance and repairs are charged to operations. Major renewals and betterments are capitalized. When assets are retired or otherwise disposed of, the cost and related accumulated depreciation are removed from the accounts and the gain or loss, if any, is included in nonoperating revenues (expenses) in the accompanying statements of revenues, expenses, and changes in net position.

(Continued)

Regional One Health capitalizes interest cost on qualified construction expenditures, net of income earned on related trusteed assets, as a component of the cost of related projects. No such interest costs were capitalized in 2016 or 2015.

All capital assets other than land are depreciated using the following lives:

Land improvements	5 to 25 years
Buildings and improvements	10 to 40 years
Fixed equipment	5 to 25 years
Movable equipment	3 to 20 years
Software	3 years

(i) Impairment of Capital Assets

Capital assets are reviewed for impairment when service utility has declined significantly. If such assets are no longer used, they are reported at the lower of carrying value or fair value. If such assets will continue to be used, the impairment loss is measured using the method that best reflects the diminished service utility of the capital asset. No charge related to impairment matters was required during 2016 or 2015.

(j) Compensated Absences

Regional One Health's employees accumulate vacation, holiday, and sick leave at varying rates depending upon years of continuous service and payroll classification, subject to maximum limitations. Upon termination of employment, employees are paid all unused accrued vacation and holiday time at regular rate of pay up to a designated maximum number of days. Since the employees' vacation and holiday time accumulates and vests, an accrual for this liability is included in accrued expenses and other current liabilities in the accompanying statements of net position. An accrual is recognized for unused sick leave expected to be paid to employees eligible to retire.

(k) Net Position

Net position of Regional One Health is classified into the following components:

- *Net investment in capital assets* consists of capital assets net of accumulated depreciation, net of the related debt.
- *Restricted* includes those amounts with limits on their use that are externally imposed (by creditors, grantors, contributors, or the laws and regulations of other governments).
- *Unrestricted* represents remaining amounts that do not meet either of the above definitions.

When Regional One Health has both restricted and unrestricted resources available to finance a particular program, it is Regional One Health's policy to use restricted resources before unrestricted resources.

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Regional One Health Foundation historically and to-date does not maintain donor-restricted endowment funds, or any Board-designated endowments. Regional One Health Foundation's Board has interpreted Tennessee's State Prudent Management of Institutional Funds Act as requiring the preservation of the fair value of the original gift as of the gift date of the donor-restricted endowment funds, absent explicit donor stipulations to the contrary. In all material respects, income from Regional One Health Foundation's donor-restricted endowment funds is itself restricted to specific donor-directed purposes, and is, therefore, accounted for within restricted amounts until expended in accordance with the donor's wishes. Regional One Health Foundation oversees individual donor-restricted endowment funds to ensure that the fair value of the original gift is preserved.

(l) Statement of Revenues, Expenses, and Changes in Net Position

For purposes of presentation, transactions deemed by management to be ongoing, major, or central to the provision of healthcare services, other than financing costs, are reported as operating revenues and operating expenses. Other transactions, such as investment income, interest expense, appropriations from Shelby County, gain (loss) on disposal of capital assets, and equity in earnings are reported as nonoperating revenues and expenses.

(m) Net Patient Service Revenue

Net patient service revenue is reported at estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive revenue adjustments due to future audits, reviews, and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered and such amounts are adjusted in future periods as adjustments become known or as years are no longer subject to such audits, reviews, and investigations. Changes in estimates related to prior cost reporting periods resulted in an increase in net patient service revenue of approximately $1,332,000 and $587,000 in 2016 and 2015, respectively.

(n) Charity Care

Regional One Health provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because Regional One Health does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

When defining charity care, Regional One Health employs the Federal Poverty Guideline (FPG) to determine the level of discount uninsured patients receive. The level by which assistance is determined is through the scale set by the Department of Health and Human Services, which includes factors such as residents per household and income. Regional One Health's methodology includes all patients that fall at or below the 150% FPG baseline. Regional One Health does not have a cap to which patients will not qualify for a discount. Additionally, Regional One Health's charity care guidelines provide for an expansive definition of charity care patients, including an upfront discount from standard charges for uninsured patients.

(Continued)

(o) Income Taxes

Regional One Health is a not-for-profit corporation organized by the approval of the Board of County Commissioners of the County and qualifies as a tax-exempt entity under Internal Revenue Code (IRC) Section 501(a) as organizations described in IRC Section 501(c)(3), and therefore, related income is generally not subject to federal or state income taxes, except for tax on income from activities unrelated to its exempt purpose as described in IRC Section 512(a). Thus, no provision for income taxes has been recorded in the accompanying financial statements.

(p) Appropriations

The County has historically appropriated funds annually to Regional One Health to partially offset the cost of medical care for indigent residents of the County. Appropriations for indigent residents from the County were $27,408,000 and $26,816,000 for the years ended June 30, 2016 and 2015, respectively. Appropriations from the County are reported as nonoperating revenue in the accompanying statements of revenues, expenses, and changes in net position.

(q) Recent Accounting Pronouncements

In February 2015, the GASB issued Standard 72: *Fair Value Measurement and Application*, which addresses the accounting and financial reporting issues related to fair value measurements. This standard defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an ordinary transaction between market participants. GASB 72 requires disclosures to be made about fair value measurements, the level of fair value hierarchy and valuation techniques. Additional disclosures are required regarding investments that are valued by net asset per share. This standard is effective for the financial statements for periods beginning after June 15, 2015 (the Regional One Health 2016 fiscal year). Regional One Health adopted this standard on July 1, 2015. There is no effect on the financial statements related to the adoption of this standard, but additional disclosures are included in note 2 to the financial statements.

(r) Subsequent Events

Regional One Health has evaluated subsequent events through November 11, 2016, the date at which the financial statements were issued, and determined that there are no subsequent events to be recognized in the financial statements and related notes.

(s) Reclassifications

Certain reclassifications have been made to the 2015 financial statements to conform to the 2016 presentation.

(Continued)

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)
Notes to Basic Financial Statements
June 30, 2016 and 2015

(2) Deposits, Investments and Reverse Repurchase Agreement

(a) Deposits and Investments

The composition of cash and cash equivalents follows:

	2016	2015
Cash	$ 16,690,503	9,744,655
Money market funds	19,547	19,504
	$ 16,710,050	9,764,159

Investments and restricted investments include amounts held by both Regional One Health and Regional One Health Foundation.

The composition of investments and restricted investments follows:

	2016	2015
U.S. agencies	$ 50,601,257	64,108,405
Certificates of deposit	8,246,030	896,146
Corporate bonds	49,200,185	36,228,983
Demand deposit accounts and money market funds	3,147,369	6,385,686
U.S. government funds	356,578	—
Common stock	5,723,146	8,720,123
Accrued interest	629,336	521,609
	$ 117,903,901	116,860,952

The fair value hierarchy of investments follows:

	2016			
	Level 1	Level 2	Level 3	Total
U.S. agencies $	—	50,601,257	—	50,601,257
Certificates of deposit	—	8,246,030	—	8,246,030
Corporate bonds	—	49,200,185	—	49,200,185
Demand deposit accounts and money market funds	—	3,147,369	—	3,147,369
U.S. government funds	—	356,578	—	356,578
Common stock	5,723,146	—	—	5,723,146
Accrued interest	629,336	—	—	629,336
$	6,352,482	111,551,419	—	117,903,901

(Continued)

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)
Notes to Basic Financial Statements
June 30, 2016 and 2015

	2015			
	Level 1	Level 2	Level 3	Total
U.S. agencies $	—	64,108,405	—	64,108,405
Certificates of deposit	—	896,146	—	896,146
Corporate bonds	—	36,228,983	—	36,228,983
Demand deposit accounts and money market funds	—	6,385,686	—	6,385,686
U.S. government funds	—	—	—	—
Common stock	8,720,123	—	—	8,720,123
Accrued interest	521,609	—	—	521,609
$	9,241,732	107,619,220	—	116,860,952

At June 30, 2016, Regional One Health and Regional One Health Foundation had investments in debt securities with the following maturities:

	Fair value	Less than 6 months	6 months to 1 year	1–5 years	Over 5 years
U.S. agencies	$ 50,601,257	—	—	27,768,700	22,832,557
Corporate bonds	49,200,185	3,378,292	6,376,187	34,405,251	5,040,455
	$ 99,801,442	3,378,292	6,376,187	62,173,951	27,873,012

At June 30, 2015, Regional One Health and Regional One Health Foundation had investments in debt securities with the following maturities:

		Investment and restricted investment maturities (in years)			
	Fair value	Less than 6 months	6 months to 1 year	1–5 years	5+ years
U.S. agencies	$ 64,108,405	7,005,393	9,655,516	30,139,605	17,307,891
Corporate bonds	36,228,983	564,746	2,669,948	29,654,286	3,340,003
	$ 100,337,388	7,570,139	12,325,464	59,793,891	20,647,894

There were no investments that represented 5% or more of total investments for Regional One Health as of June 30, 2016 and 2015. At June 30, 2016, Regional One Health Foundation had one investment totaling $356,578 in the SEI Daily Income Trust Government Fund that represented 5% or more of total investments for Regional One Health Foundation. At June 30, 2015, Regional One Health Foundation had one investment totaling $512,878 in the SEI Daily Income Trust Government Fund that represented 5% or more of total investments for Regional One Health Foundation.

(Continued)

Regional One Health and Regional One Health Foundation have separate investment policies that are included below. The summary of investments throughout the financial statements includes the combined investment totals of Regional One Health and Regional One Health Foundation.

At June 30, 2016, Regional One Health's and Regional One Health Foundation's corporate bonds, collectively, had the following credit ratings per Standard and Poor's:

	Fair value	Credit rating
$	6,678,364	BBB-
	6,559,437	BBB
	17,069,371	BBB+
	472,500	BB
	5,418,430	A-
	9,487,056	A
	921,745	A+
	2,389,373	AA-
	—	AA+
	203,909	
$	49,200,185	

At June 30, 2015, Regional One Health's and Regional One Health Foundation's corporate bonds, collectively, had the following credit ratings per Standard and Poor's:

	Fair value	Credit rating
$	4,784,327	BBB-
	6,717,033	BBB
	6,345,414	BBB+
	7,610,862	A-
	8,436,865	A
	895,896	A+
	1,159,164	AA-
	279,422	AA+
$	36,228,983	

As of June 30, 2016, Regional One Health's investment strategy, per its investment policy, is to provide liquidity to fund ongoing operating needs and to act as a repository for both the accumulation

(Continued)

of cash reserves needed to cushion economic down cycles and to provide cash earmarked for strategic needs.

The portfolio objectives of Regional One Health, listed in order of importance, are as follows:

1. Preserve principal
2. Maintain sufficient liquidity to meet future cash needs
3. Maintain a diversified portfolio to minimize risk
4. Maximize return subject to the above criteria

The duration of the bond investment portfolio should not exceed six years.

The authorized investments are as follows:

1. *Commercial Paper* – Any commercial paper issued by a domestic corporation with a maturity of 270 or less days that carries at least the second highest rating by a recognized investor service, preferably Standard and Poor's and Moody's Investors Service. Commercial paper shall not represent more than 50% of the portfolio.
2. *U.S. Treasury Securities* – U.S. Treasury notes, bills, and bonds. There is no upper limit restriction as to the maximum dollar amount or percentage of the portfolio that may be invested in U.S. Treasury securities.
3. *Bank Obligations* – Any certificate of deposit, time deposit, Eurodollar CD issued by a foreign branch of a U.S. bank, bankers' acceptance, bank note, or letter of credit issued by a (U.S.) bank possessing at least the second highest rating by a recognized investor services, preferably Standard and Poor's and Moody's Investors Service. Bank obligations (excluding repurchase agreements, commercial paper, and investments held by money market and mutual funds) may not represent more than 30% of the portfolio. In addition, brokered CDs may be purchased from institutions, irrespective of the institutions' debt ratings, so long as the obligations are fully backed by the FDIC.
4. *Repurchase Agreements* – Any Repurchase Agreement purchased from one of the top 25 U.S. banks or one of the primary dealers regulated by the Federal Reserve that is at least 102% collateralized by U.S. government obligations. Repurchase Agreements may not represent more than 20% of the portfolio.
5. *Money Market Funds* – Any open-end money market fund regulated by the U.S. government under Investment Company Act Rule 2a-7. Any investment fund regulated by a Registered Investment Advisor under Rule 3c-7. Such fund investment guidelines must state that "the fund will seek to maintain a $1 per share net asset value." Regional One Health's investment in any one fund may not exceed 30% of the assets of the fund into which it is invested.

(Continued)

6. *United States Government Obligations* – Any obligation issued or backed (federal agencies) by the U.S. government. No more than 25% may be invested in obligations of any one federal agency.

7. *Corporate Bonds* – Obligations of United States and foreign corporations (including trusts and municipalities of the United States) that carry at least the fourth highest rating by a recognized rating service, preferably Standard and Poor's or Moody's Investors Service. Corporate bonds, held directly and initially qualifying in one of the above categories, which have been downgraded below the third highest rating, may be sold at the discretion of management. Corporate bonds may not represent more than 40% of the portfolio, foreign corporate bonds may not represent more than 20% of the portfolio, and corporate bonds in the fourth highest rating category may not represent more than 20% of the portfolio.

8. *Bond Mutual Funds* – Any publicly available investment registered under the Investment Company Act of 1940 as an open-end mutual fund that is managing a portfolio or debt obligations. Each mutual fund should have a minimum of $2 billion invested and hold at least 100 different debt obligations. Bond mutual funds can only hold the Authorized Investments meeting all the criteria described above. Additionally, bond mutual funds can hold corporate bonds in the fifth and sixth highest ratings category as long as such holdings do not exceed 10% of the portfolio. Corporate bonds, held via bond mutual funds and initially qualifying in one of the above categories, which have been downgraded below the sixth highest rating, may not exceed 2% of the portfolio.

9. *Equity Mutual Funds* – Any publicly available investment registered under the Investment Company Act of 1940 as an open-end mutual fund that is managing a portfolio of equity securities. Each mutual fund should have a minimum of $2 billion invested and hold at least 100 different equity securities. Such holdings should not represent more than 20% of the portfolio, Equity Mutual Funds can hold equity securities (including common and preferred stocks) of the 1,000 largest corporations in terms of market capitalization and inclusion in the Russell 1000 Index (representing large cap stocks) that are traded on U.S. exchanges reported in the Wall Street Journal.

10. *Debt Buy Back* – Any debt obligation backed directly by Regional One Health may be purchased so long as it is purchased at a discount.

11. Notwithstanding the above criteria, direct investments other than mutual funds that meet the following criteria are not permitted: corporations with more than 25% of revenues derived from the manufacture and sale of firearms, ammunition, and ammunition magazines to the general citizenry.

The Finance Committee of the Board of Directors meets periodically to review asset allocation, portfolio performance, and overall adherence to the investment policy guidelines.

As of June 30, 2016 and 2015, Regional One Health Foundation utilized one investment manager. This manager is required to make investments in adherence to Regional One Health Foundation's current investment policy and objectives.

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Regional One Health Foundation follows an investment strategy focused on maximizing total return (i.e., aggregate return from capital appreciation and dividend and interest income) while adhering to certain restrictions designed to promote a conservative portfolio.

Specifically, the primary objective of Regional One Health Foundation's investment management strategy is to maintain an investment portfolio designed to generate a high level of current income with above-average stability.

Guidelines for investments and cash equivalents for Regional One Health Foundation follow:

1. Regional One Health Foundation's assets may be invested only in investment grade bonds rated Baa or higher as determined by Moody's Investors Service, or the equivalent by another acceptable rating agency.

2. The overall market-weighted quality rating of the bond portfolio shall be no lower than A.

3. Regional One Health Foundation's assets may be invested only in commercial paper rated P-2 (or equivalent) or higher by Moody's Investors Service or by another acceptable rating agency.

4. The market-weighted maturity of the base portfolio shall be no longer than 10 years.

5. Quality of the equity securities will be governed by the Federal Employee Retirement and Income Security Act, the Tennessee guidelines for investing trust funds and the "prudent man rule."

6. Conservative option strategies may be used, with a goal of increasing the stability of the portfolio.

Regional One Health Foundation limits investments in common stock to 40% of its investment portfolio. The remainder of the portfolio is to be invested in fixed-income investments.

Investment income comprises the following:

		2016	2015
Dividend and interest income	$	3,685,929	3,925,550
Net decrease in fair value of investments		(619,180)	(347,515)
	$	3,066,749	3,578,035

(b) Reverse Repurchase Agreement

In November 2013, Regional One Health entered into a Master Repurchase Agreement with a financial institution which allows Regional One Health to enter into transactions using reverse repurchase agreements, whereas Regional One Health in exchange for a predetermined amount cash, sells or pledges (i.e., reverse repurchases) its own investments (with a market value approximately 5% higher than the predetermined amount) and agrees to repurchase the investments at a future date or on demand for the same predetermined amount of cash plus interest for the period between the two transaction

(Continued)

dates. Also, Regional One Health is entitled to any maturity or interest payments received on the investments subject to the reverse repurchase agreement (prior to repurchase) and occasionally Regional One Health's investments are substituted, especially when they are redeemed by the issuer.

Regional One Health uses these agreements as a cash management strategy primarily related to the $50,000,000 cash influx received in July each year, from the County and State appropriations, that is used by operations over the remainder of the fiscal year. Therefore, it allows Regional One Health to invest this excess working capital cash for longer periods of time at rates higher than the interest charged under the reverse repurchase agreements. Consequently, the outstanding amount of repurchase obligations can be as high as $50,000,000 during any given fiscal year and should be zero shortly following the $50,000,000 cash influx in July.

These transactions are formally approved within the investment policy of Regional One Health and the Master Repurchase Agreement, which stays in effect with the financial institution, until either party terminates. There were no violations of the Master Repurchase Agreement or the Regional One Health investment policy during the years ended June 30, 2016 and 2015.

During the fiscal year ended June 30, 2016, the outstanding balance of reverse repurchase agreement obligations ranged between zero and approximately $45,000,000, and was $11,893,738 at June 30, 2016, which is reported as a liability obligation under reverse repurchase agreements on the statement of net position. During the fiscal year ended June 30, 2015, the outstanding balance of reverse repurchase agreement obligations ranged between zero and approximately $40,000,000, and there was no outstanding obligations at June 30, 2015. Interest expense related to the reverse repurchase agreements was $132,000 and $82,000 for the years ended June 30, 2016 and 2015, respectively, and is reported within interest expense on the statements of revenues, expenses and changes in net position. In July 2016, Regional One Health repurchased the outstanding reverse repurchase agreement obligations of $11,893,738 as of June 30, 2016.

(3) Business and Credit Concentrations

Regional One Health grants credit to patients, substantially all of whom are local area residents. Regional One Health generally does not require collateral or other security in extending credit to patients; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans, or policies (e.g., Medicare, Medicaid, Blue Cross, and commercial insurance policies).

(Continued)

The mix of receivables from patients and third-party payors follows, before application of related valuation allowances:

	2016	2015
Patients	32%	33%
Commercial insurance	30	29
Medicare	21	19
Medicaid/TennCare	17	19
	100%	100%

(4) Other Receivables

The composition of other receivables follows:

	2016	2015
Accounts receivable from University of Tennessee Center for Health Services	$ 1,497,523	1,741,599
Accounts receivable from the County	2,234,667	154,680
Accounts receivable from the State of Tennessee	4,435,272	3,547,429
Grants receivable	343,803	1,025,254
Accounts receivable from UT Regional One Physicians	1,648,543	1,295,526
Other	3,651,607	3,203,927
	$ 13,811,415	10,968,415

(5) Other Current Assets

The composition of other current assets follows:

	2016	2015
Inventories	$ 3,383,077	3,280,696
Prepaid expenses	3,899,094	3,755,023
	$ 7,282,171	7,035,719

(Continued)

SHELBY COUNTY HEALTH CARE CORPORATION
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(6) Capital Assets

Capital assets and related activity consist of the following:

	Balances at June 30, 2015	Additions	Retirements	Transfers	Balances at June 30, 2016
Capital assets not being depreciated:					
Construction in progress	$ 2,871,413	7,643,499	—	(9,449,804)	1,065,108
Land	4,313,278	—	—	—	4,313,278
Total book value of capital assets not being depreciated	7,184,691	7,643,499	—	(9,449,804)	5,378,386
Capital assets being depreciated:					
Land improvements	7,390,983	—	—	63,149	7,454,132
Buildings	66,758,749	—	—	—	66,758,749
Fixed equipment	141,514,569	1,417,446	—	3,895,583	146,827,598
Movable equipment	155,015,751	3,631,073	—	2,859,061	161,505,885
Software	36,230,377	969,479	(129,744)	2,632,011	39,702,123
Total book value of capital assets being depreciated	406,910,429	6,017,998	(129,744)	9,449,804	422,248,487
Less accumulated depreciation for:					
Land improvements	(5,961,366)	(186,154)	—	—	(6,147,520)
Buildings	(58,019,940)	(693,881)	—	—	(58,713,821)
Fixed equipment	(102,415,516)	(5,076,784)	—	—	(107,492,300)
Movable equipment	(128,303,012)	(8,446,819)	—	—	(136,749,831)
Software	(23,387,821)	(4,168,291)	21,624	—	(27,534,488)
Total accumulated depreciation	(318,087,655)	(18,571,929)	21,624	—	(336,637,960)
Capital assets being depreciated, net	88,822,774	(12,553,931)	(108,120)	9,449,804	85,610,527
Capital assets, net	$ 96,007,465	(4,910,432)	(108,120)	—	90,988,913

(Continued)

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	Balances at June 30, 2014	Additions	Retirements	Transfers	Balances at June 30, 2015
Capital assets not being depreciated:					
Construction in progress	$ 1,585,034	5,039,260	—	(3,752,881)	2,871,413
Land	5,835,326	—	—	(1,522,048)	4,313,278
Total book value of capital assets not being depreciated	7,420,360	5,039,260	—	(5,274,929)	7,184,691
Capital assets being depreciated:					
Land improvements	7,269,474	121,509	—	—	7,390,983
Buildings	65,236,701	—	—	1,522,048	66,758,749
Fixed equipment	138,900,279	1,801,265	—	813,025	141,514,569
Movable equipment	150,758,409	4,084,035	(223,349)	396,656	155,015,751
Software	32,839,280	847,897	—	2,543,200	36,230,377
Total book value of capital assets being depreciated	395,004,143	6,854,706	(223,349)	5,274,929	406,910,429
Less accumulated depreciation for:					
Land improvements	(5,786,325)	(175,041)	—	—	(5,961,366)
Buildings	(57,310,792)	(709,148)	—	—	(58,019,940)
Fixed equipment	(97,386,461)	(5,029,055)	—	—	(102,415,516)
Movable equipment	(119,918,449)	(8,577,235)	192,672	—	(128,303,012)
Software	(19,673,313)	(3,714,508)	—	—	(23,387,821)
Total accumulated depreciation	(300,075,340)	(18,204,987)	192,672	—	(318,087,655)
Capital assets being depreciated, net	94,928,803	(11,350,281)	(30,677)	5,274,929	88,822,774
Capital assets, net	$ 102,349,163	(6,311,021)	(30,677)	—	96,007,465

(7) Equity Investments

The composition of equity method investments follows:

	2016	2015
Investment in Memphis Medical Center Air Ambulance Service, Inc. (MMCAAS)	$ 10,614,448	8,586,001
Regional One RH MOB 1 SPE, LLC	1,066,223	1,113,875
Investment in Central Billing Office	1,300,000	1,300,000
	$ 12,980,671	10,999,876

MMCAAS is a nonmember not-for-profit corporation organized to operate an air ambulance service for the transportation of medical supplies, equipment, and injured or sick persons. MMCAAS was organized by

(Continued)

Regional One Health and two other local healthcare systems. Regional One Health appoints one-third of the board members of MMCAAS and is entitled to one-third of the net assets of MMCAAS in the event of dissolution. MMCAAS maintains separate financial statements, which can be obtained by writing to Hospital Wing, 1080 Eastmoreland Avenue, Memphis, Tennessee 38104 or by calling 901-522-5321.

Regional One Properties, Inc., a wholly owned subsidiary of Shelby County Health Care Corporation, is a 50% owner in Regional One RH MOB 1 SPE, LLC. This joint venture with a local developer and other various owners was to purchase an office building in Memphis, Tennessee with intentions of converting this building into medical space and offices. RH MOB 1 SPE, LLC maintains separate financial statements, which can be obtained by writing to 6555 Quince, 3330 Preston Ridge Road, Suite 380, Alpharetta, Georgia 30005 or by calling 404-255-6358 extension 229.

The Central Billing Office (CBO) was formed by Regional One Health and two other local healthcare entities, with Regional One Health being a one-third owner and appointing one-third of the board members. The CBO performs billing and collection services for its three members, including billing for University of Tennessee Regional One Physicians (UTROP) services for Regional One Health. The CBO maintains separate financial statements, which can be obtained by writing to the Partners Central Billing Office, 1407 Union Avenue, Suite 200, Memphis, Tennessee 38104 or by calling 901-275-3702

(8) New Market Tax Credit Program and Long-term Debt

Regional One Health entered into a transaction with SunTrust Community Capital, LLC in September 2013 to obtain financing through the New Market Tax Credit (NMTC) Program sponsored by the Department of Treasury. The NMTC Program permits certain corporate taxpayers to receive a credit against federal income taxes for making qualified equity investments (QEI) in community development entities. The credit provided to the investor totals 39% of the initial value of the QEI and is claimed over a seven-year credit allowance period.

As part of this transaction Regional One Health and SunTrust Community Capital, LLC contributed approximately $19,222,000 and $7,328,000, respectively, to The Med Memphis Investment Fund, LLC, an entity created to provide funding for investments in special purposes entities called community development entities (CDEs). Regional One Health provided funding and received a notes receivable as part of the NMTC program as follows:

		2016	2015
Notes receivable	$	19,221,600	19,221,600

The notes receivable requires interest only payments of 1.119% annually on the unpaid principal balance, which is due on February 15 following the end of a calendar year, beginning February 15, 2014 through February 15, 2021. Beginning on February 15, 2022, principal and interest payments will be due and will continue annually until the maturity of the notes receivable on February 15, 2035. Additional principal payments are required related to this notes receivable in an amount equal to 90% of net cash flow, as defined in the borrowers operating agreement.

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Shelby County Health Care Properties, Inc. was formed as part of the NMTC Program with Regional One Health as the sole member. Shelby County Health Care Properties, Inc. executed note payable agreements on September 13, 2013 with several CDE's that provide for borrowings of $26,550,000. The proceeds from these notes payable were used for the expansion of Regional One Health and are treated as a "qualified low-income community investment" for purposes of generating new markets tax credits under Section 45d of the Internal Revenue Code of 1986, as amended.

Long-term debt related to the NMTC program is summarized as follows:

	2016	2015
Note payable to RGC 2, LLC, interest paid quarterly at an interest rate of 1.00%, the maturity date is September 13, 2038	$ 5,500,000	5,500,000
Note payable to NDC New Markets Investments LXXXIII, LLC, interest paid quarterly at an interest rate of 1.00%, the maturity date is September 13, 2038	6,790,000	6,790,000
Note payable to CHHS Subsidiary CDE 7, LLC, interest paid quarterly at an interest rate of 1.00%, the maturity date is September 13, 2038	7,760,000	7,760,000
Note payable to ST CDE XIV, LLC, interest paid quarterly at an interest rate of 1.00%, the maturity date is September 13, 2038	6,500,000	6,500,000
	$ 26,550,000	26,550,000

A schedule of changes in the long-term debt related to the NMTC program for 2016 follows:

	Date of Issuance	Balance July 1, 2015	Additions	Retired	Balance June 30, 2016	Due within one year
Note payable to RGC 2, LLC	9/13/2013	$ 5,500,000	—	—	5,500,000	—
Note payable to NDC New Markets Investment LXXXIII, LLC	9/13/2013	6,790,000	—	—	6,790,000	—
Note payable to CHHS subsidiary CDE 7, LLC	9/13/2013	7,760,000	—	—	7,760,000	—
Note payable to ST CDE XIV, LLC	9/13/2013	6,500,000	—	—	6,500,000	—
		$ 26,550,000	—	—	26,550,000	—

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A schedule of changes in the long-term debt related to the NMTC program for 2015 follows:

	Date of Issuance	Balance July 1, 2014	Additions	Retired	Balance June 30, 2015	Due within one year
Note payable to RGC 2, LLC	9/13/2013	$ 5,500,000	—	—	5,500,000	—
Note payable to NDC New Markets Investment LXXXIII, LLC	9/13/2013	6,790,000	—	—	6,790,000	—
Note payable to CHHS subsidiary CDE 7, LLC	9/13/2013	7,760,000	—	—	7,760,000	—
Note payable to ST CDE XIV, LLC	9/13/2013	6,500,000	—	—	6,500,000	—
		$ 26,550,000	—	—	26,550,000	—

The aggregate annual maturities of the long-term debt at June 30, 2016 are as follows:

2017	$ —
2018	—
2019	—
2020	—
2021	—
Thereafter	26,550,000
	$ 26,550,000

The annual interest payments associated with long-term debt are as follows:

2017	$ 265,500
2018	265,500
2019	265,500
2020	556,350
2021	79,597
Thereafter	28,986,051
	$ 30,418,498

The principal balance is due, for each of the notes payable listed above, in its entirety on the stated maturity date. Interest paid was approximately $265,500 and $270,000 in 2016 and 2015, respectively.

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(9) Accrued Expenses and Other Current Liabilities

The composition of accrued expenses and other current liabilities follows:

	2016	2015
Due to third-party payors	$ 17,624,000	16,013,000
Compensated absences	8,917,099	9,341,125
Deferred grant revenue	248,071	164,375
Accrued payroll and withholdings	12,827,951	7,487,149
Accrued employee healthcare claims	2,808,000	2,715,000
Professional and general liability costs	1,800,000	2,300,000
Other	302,729	297,027
	$ 44,527,850	38,317,676

(10) Net Patient Service Revenue

Regional One Health has agreements with governmental and other third-party payors that provide for reimbursement to Regional One Health at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between billings at established rates for services and amounts reimbursed by third-party payors. A summary of the basis of reimbursement with major third-party payors follows:

- *Medicare* – Substantially all acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. Certain types of exempt services and other defined payments related to Medicare beneficiaries are paid based on cost reimbursement or other retroactive-determination methodologies. Regional One Health is paid for retroactively determined items at tentative rates with final settlement determined after submission of annual cost reports by Regional One Health and audits thereof by Regional One Health fiscal intermediary.

  Regional One Health's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization. Regional One Health's Medicare cost reports have been audited and settled by Regional One Health's fiscal intermediary through June 30, 2013. Revenue from the Medicare program accounted for approximately 24% and 21% of Regional One Health's net patient service revenue for the years ended June 30, 2016 and 2015, respectively.

- *TennCare* – Under the TennCare program, patients traditionally covered by the State of Tennessee Medicaid program and certain members of the uninsured population enroll in managed care organizations that have contracted with the State of Tennessee to ensure healthcare coverage to their enrollees. Regional One Health contracts with the managed care organizations to receive reimbursement for providing services to these patients. Payment arrangements with these managed care organizations consist primarily of prospectively determined rates per discharge, discounts from established charges, or prospectively determined per diem rates. Revenue from the TennCare program

(Continued)

accounted for approximately 22% of Regional One Health's net patient service revenue for both the years ended June 30, 2016 and 2015.

Regional One Health has historically received incremental reimbursement in the form of Essential Access payments through its participation in the TennCare Program. Amounts received by Regional One Health under this program were approximately $66,200,000 and $59,700,000 in 2016 and 2015, respectively. These amounts have been recognized as reductions in related contractual adjustments in the accompanying statements of revenues, expenses, and changes in net position. There can be no assurance that Regional One Health will continue to qualify for future participation in this program or that the program will not ultimately be discontinued or materially modified. Any material reduction in such funds has a correspondingly material adverse effect on Regional One Health's operations.

- *Arkansas Medicaid* – Substantially all inpatient and outpatient services rendered to Arkansas Medicaid program beneficiaries are paid under prospective reimbursement methodologies established by the State of Arkansas. Certain other reimbursement items (principally inpatient nursery services and medical education costs) are based upon cost reimbursement methodologies. Regional One Health is reimbursed for cost reimbursable items at tentative rates with final settlement determined after submission of annual cost reports by Regional One Health and audits thereof by the Arkansas Department of Health and Human Services (DHHS). Regional One Health's Arkansas Medicaid cost reports have been audited and settled by the Arkansas DHHS through June 30, 2012. Revenue from the State of Arkansas Medicaid program accounted for approximately 2% of Regional One Health's net patient service revenue for both years ended June 30, 2016 and 2015.

  Regional One Health has historically received incremental reimbursement in the form of Upper Payment Limit (UPL) and additional appropriation payments through its participation in the State of Arkansas Medicaid program. The net benefit for Regional One Health associated with this program, totaling approximately $2,500,000 and $2,300,000 for the years ended June 30, 2016 and 2015, respectively, has been recognized as a reduction in related contractual adjustments in the accompanying statements of revenues, expenses, and changes in net position. There can be no assurance that Regional One Health will continue to qualify for future participation in this program or that the program will not ultimately be discontinued or materially modified.

- *Mississippi Medicaid* – Inpatient and outpatient services rendered to Mississippi Medicaid program beneficiaries are generally paid based upon prospective reimbursement methodologies established by the State of Mississippi. Revenue from the State of Mississippi Medicaid program accounted for approximately 2% of Regional One Health's net patient service revenue for both the years ended June 30, 2016 and 2015.

  Regional One Health has historically received incremental reimbursement in the form of Upper Payment Limit (UPL) and additional appropriation payments through its participation in the State of Mississippi Medicaid program. The net benefit for Regional One Health associated with this program, totaling approximately $5,400,000 for both the years ended June 30, 2016 and 2015, and has been recognized as a reduction in related contractual adjustments in the accompanying statements of revenues, expenses, and changes in net position.

(Continued)

- *Other* – Regional One Health has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The reimbursement methodologies under these agreements include prospectively determined rates per discharge, per diem amounts, and discounts from established charges.

The composition of net patient service revenue follows:

	2016	2015
Gross patient service revenue	$ 1,152,642,901	1,106,384,701
Less provision for contractual and other adjustments	767,779,648	670,979,457
Less provision for bad debts	22,507,087	88,270,282
Net patient service revenue	$ 362,356,166	347,134,962

The composition of incremental reimbursement from various state agencies for participation in TennCare/Medicaid programs follows:

	2016	2015
TennCare essential access	$ 66,150,059	59,654,700
Arkansas UPL/Disproportionate share	2,497,816	2,326,509
Mississippi disproportionate share	5,360,521	5,405,965
Total payments	$ 74,008,396	67,387,174

The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as part of the American Recovery and Reinvestment Act of 2009 and signed into law in February 2009. In the context of the HITECH Act, Regional One Health must implement a certified Electronic Health Record (EHR) in an effort to promote the adoption and "meaningful use" of health information technology (HIT). The HITECH Act includes significant monetary incentives and payment penalties meant to encourage the adoption of EHR technology. Regional One Health received approximately $1,792,000 and $391,000 of incentive payments related to EHR implementation for the years ended June 30, 2016 and 2015, respectively. These amounts are included in net patient service revenue within the statements of revenues, expenses, and change in net position.

(11) Charity Care

Regional One Health maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. Charges foregone, based on established rates, were approximately $291,300,000 and $283,700,000 in 2016 and 2015, respectively. Included in the charges foregone is the upfront discount applied to all uninsured patients of approximately $140,000,000 and $98,300,000 in 2016 and 2015, respectively, as Regional One Health does not pursue collection on these amounts. Regional One Health's estimated cost of caring for charity care patients for the years ended June 30, 2016 and 2015, was approximately $88,300,000 and $82,600,000, respectively.

(Continued)

(12) Retirement Plans

(a) Defined Benefit Plan

Regional One Health contributes to the Shelby County Retirement System (the Retirement System), a cost-sharing single-employer defined benefit public employee retirement system (PERS) established by Shelby County, Tennessee. The Retirement System is administered by a board, the majority of whose members are nominated by the Shelby County Mayor, subject to approval by the Shelby County Board of Commissioners. The Retirement System issues a publicly available financial report that includes financial statements and required supplementary information. That report may be obtained by writing to the Shelby County Retirement System, Suite 950, 160 North Main, Memphis, Tennessee 38103 or by calling 901-545-3570.

Shelby County provides office space and certain administrative services at no cost to the Retirement System. All other costs to administer the plan are paid from plan earnings.

The Retirement System consists of three plans (Plans A, B, and C). In 1990, Plans A and B were merged into one reporting entity, whereby total combined assets of the merged plans are available for payment of benefits to participants of either of the two previously existing plans. In 2005, Plan C was added and merged with Plans A and B for funding purposes. While the plans were merged, the Retirement System has retained the membership criteria of the previous plans, which are as follows:

- Plan C, a contributory cost-sharing multiple-employer defined benefit pension plan for employees who are also eligible for Plan A,
- Plan B, a contributory cost-sharing multiple-employer defined benefit pension plan for employees hired prior to December 1, 1978, and
- Plan A, a contributory cost-sharing multiple-employer defined benefit pension plan for employees hired on or after December 1, 1978, and those employees that elected to transfer to Plan A from Plan B before January 1, 1981. Plan A was noncontributory for all years prior to 2013.

The Shelby County Board of Commissioners establishes the Retirement System's benefit provisions. Regional One Health pays the established contribution rate to the Shelby County Pension Plan with the employee contribution being withheld from employee pay and Regional One Health paying the employer contribution rate. Regional One Health has no further obligation once the employee leaves Regional One Health. The Retirement System provides retirement, as well as survivor and disability defined benefits.

The Retirement System's funding policy for employee contribution requirements is established by the Board of Administration of the Retirement System. The Shelby County Board of Commissioners establishes the Retirement System's funding policy for employer contribution requirements. For fiscal years 2016, 2015, and 2014, the employer contribution requirements were based on the actuarially determined contribution rates, which were 13.26%, 13.35%, and 13.26%, respectively.

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The actuarially determined contribution rate was calculated using a projected unit credit service pro rata cost method for Plan A, Plan B, and Plan C participants.

For fiscal years 2016, 2015, and 2014, the following contributions were made to the defined benefit plans:

		2016	2015	2014
Regional One Health's contributions:				
Plan A	$	168,514	266,282	367,032
Plan B		—	233	2,020
Plan C		39,839	157,330	82,447
Employee contributions:				
Plan A	$	15,971	27,224	20,783
Plan B		—	82	709
Plan C		15,259	24,700	23,343

The contributions as a percentage of earned compensation were the same as those for the Retirement System. Regional One Health contributed 100% of its required contributions in 2016, 2015, and 2014.

(b) Defined Contribution Plan

Effective October 1, 2009, Regional One Health established, under the authority of its Board of Directors, The Regional Medical Center at Memphis 403(b) Retirement Plan, a defined contribution pension plan covering employees 21 years of age and older who have completed one year of service. The plan is administered by Regional One Health. The plan provides for a 100% employer match on employee contributions up to 4% of employee compensation. Participants are immediately vested in their contributions plus actual earnings thereon. Participants vest 20% in the employers matching contributions after two years of service, 50% after three years, 75% after four years, and 100% after five years. Forfeitures remain in the plan for the benefit of other participants. Regional One Health contributed approximately $2,800,000 and $2,400,000 to the 403(b) plan for the years ended June 30, 2016 and 2015, respectively. 403(b) plan participants contributed approximately $5,100,000 and $4,300,000 to the 403(b) plan for the years ended June 30, 2016 and 2015, respectively.

Effective December 1, 2010, Regional One Health established, under the authority of its Board of Directors, The Regional Medical Center at Memphis Nonqualified Supplemental Retirement Plan (Supplemental Retirement Plan). The plan is administered by Regional One Health. The Supplemental Retirement Plan was formed under Section 457(f) of the IRC of 1986, and management believes that it complies with all provisions applicable to a nonqualified deferred compensation plan under IRC Section 409A. Plan participants contributed approximately $757,000 and $194,000 to the plan for the years ended June 30, 2016 and 2015, respectively.

(13) Postretirement Benefit Plan

Regional Medical Center Healthcare Benefit Plan (the Plan) is a single-employer defined benefit healthcare plan sponsored and administered by Regional One Health. The Plan provides medical and life insurance

(Continued)

benefits to eligible retirees and their spouses. Regional One Health's Board of Directors is authorized to establish and amend all provisions. Regional One Health does not issue a publicly available financial report that includes financial statements and required supplementary information for the Plan.

During fiscal year 2010, Regional One Health's Board of Directors approved a plan amendment that eliminated medical coverage for those employees who did not have 15 years of service as of December 31, 2009 and eliminated life insurance coverage for those employees retiring January 1, 2010 or later.

Per GASB Statement No. 45, *Accounting and Financial Reporting Employers for Postemployment Benefits Other Than Pensions*, for financial reporting purposes an actuarial valuation is required at least biennially for postretirement benefit plans with a total membership of 200 or more. Regional One Health's postretirement benefit plan had approximately 308 members as of the last actuarial valuation of June 30, 2016.

(a) Funding Policy

The contribution requirements of employees and the Plan are established and may be amended by Regional One Health's Board of Directors. Monthly contributions are required by retirees who are eligible for coverage. Regional One Health pays for costs in excess of required retiree contributions. These contributions are assumed to increase based on future medical plan cost increases. For fiscal 2016 and 2015, Regional One Health contributed approximately $959,000 and $1,181,000, respectively, net of retiree contributions, to the Plan. Plan members receiving benefits contributed approximately $154,000 in fiscal 2016 and $233,000 in fiscal 2015 through their required contributions. The following table summarizes the monthly contribution rates for the year beginning July 1, 2015:

	Retiree	Spouse
Pre-Medicare	$ 2,004	2,244
Pre-Medicare eligible	708	1,668

(b) Annual OPEB Cost and Net OPEB Obligation

Regional One Health's annual other postemployment benefit (OPEB) cost is calculated based on the annual required contribution of the employer (ARC), an amount actuarially determined in accordance with the parameters of GASB Statement No. 45. The ARC represents a level of funding that, if paid on an ongoing basis, is projected to cover normal cost each year and amortize any unfunded actuarial liabilities (or funding excess) over a period of 30 years. The following table shows the components of

(Continued)

Regional One Health's annual OPEB cost for fiscal 2016, the amounts actually contributed to the Plan, and changes in Regional One Health's net OPEB obligation:

		2016	2015*
Annual required contributions and annual OPEB cost	$	1,323,070	1,290,462
Contributions made		1,113,070	1,452,462
Increase (decrease) in net OPEB obligation		210,000	(162,000)
Net OPEB obligation, beginning of year		750,000	912,000
Net OPEB obligation, end of year	$	960,000	750,000

(c) Three-Year Trend Information

Fiscal year ended	Annual OPEB cost	Percentage of annual OPEB cost contributed	Net OPEB obligation
June 30, 2016	$ 1,323,070	79.0%	$ 918,679
June 30, 2015	1,350,954	107.5	646,672
June 30, 2014	1,297,799	114.6	748,180

* Regional One Health did not obtain an actuarial evaluation of the postemployment benefit plan, as allowed by relevant accounting literature, for the year ended June 30, 2015, so the results reported above are related to the June 30, 2014 valuation.

(d) Funded Status and Funding Progress – Required Supplementary Information

As of July 1, 2015, the Plan was not funded. The actuarial accrued liability for benefits was $19,271,148 resulting in an unfunded actuarial accrued liability (UAAL) of $19,271,148.

Actuarial valuations of an ongoing plan involve estimates of the value of reported amounts and assumptions about the probability of occurrence of events far into the future. Examples include assumptions about future employment, mortality, and the healthcare cost trend. Amounts determined regarding the funded status of the Plan and the annual required contributions of the employer are subject to continual revision as actual results are compared with past expectations and new estimates are made about the future. The schedule of funding progress, as presented below as required supplementary information, presents multiyear trend information about whether the actuarial value of plan assets is increasing or decreasing over time relative to the actuarial accrued liabilities for benefits.

(Continued)

(e) Schedule of Funding Progress – Required Supplementary Information

Analysis of the Plan's funding status follows:

Actuarial valuation date*	Actuarial value of plan assets	Actuarial accrued liability (AAL)	Plan assets less than AAL	Funded ratio	Covered payroll	AAL as of a percentage of covered payroll
July 1, 2013	$ —	20,050,142	20,050,142	—	$ 18,116,596	111.0
July 1, 2014	—	20,050,142	20,050,142	—	18,116,596	111.0
July 1, 2015	—	19,271,148	19,271,148	—	18,693,833	109.0

* All inputs for valuation is provided as of beginning of the fiscal year being actuarially valuated.

(f) Actuarial Methods and Assumptions

Projections of benefits for financial reporting purposes are based on the substantive plan (the Plan as understood by the employer and the plan members) and include the types of benefits provided at the time of each valuation and the historical pattern sharing of benefit costs between the employer and plan members to that point. The actuarial methods and assumptions used include techniques that are designed to reduce the effects of short-term volatility in actuarial accrued liabilities and the actuarial value of assets, consistent with the long-term perspective of the calculations.

In the July 1, 2015 actuarial valuation, the projected unit credit actuarial method was used. The actuarial assumptions included a 3% investment rate of return, which is a long-term rate of return on general account assets, and an annual inflation rate and annual healthcare cost trend rate of 7.1%, reducing each year until it reaches an annual rate of 4.4% in 2084. The UAAL is being amortized, using a level percentage of pay method, over a 30-year period under the Projected Unit Credit Method.

(14) Transactions with University of Tennessee Center for Health Services

Regional One Health contracts with University of Tennessee Center for Health Services (UTCHS) and University of Tennessee Medical Group (UTMG) to provide, among other things, Regional One Health's house staff, professional supervision of certain ancillary departments, and professional care for indigent patients. Regional One Health also provides its facilities as a teaching hospital for UTCHS.

Operating expenses include approximately $21,600,000 and $26,100,000 for the years ended June 30, 2016 and 2015, respectively, for all professional and other services provided by UTCHS/UTMG.

On October 1, 2014, Regional One Health and the University of Tennessee Health Science Center created a jointly governed physician's group known as the University of Tennessee Regional One Physicians (UTROP). The UTROP physician group will replace the existing relationship between Regional One Health and UTMG, and will provide Regional One Health's professional supervision of certain ancillary departments and professional care for patients. Under the UTROP professional services agreement, UTROP assigns all physician revenue to Regional One Health for a fixed contracted fee based on the number of physicians needed to operate the hospital. Regional One Health records the patient service revenue earned by these physicians as gross patient service revenue and is at risk for the collection of these amounts. The fixed fee amount paid by Regional One Health to UTROP during the 2016 and 2015 years was approximately

(Continued)

$51,300,000 and $35,600,000, respectively, and is included in purchased medical services on the statements of revenues, expenses, and changes in net position.

(15) Risk Management

Regional One Health has a self-insurance program for professional and general liability risks, both with respect to claims incurred after the effective date of the program and claims incurred but not reported prior to that date. Regional One Health has not acquired any excess coverage for its self-insurance because Regional One Health is afforded sovereign immunity in accordance with applicable statutes. Presently, sovereign immunity limits losses to $300,000 per claim. Regional One Health has recorded an accrual for self-insurance losses totaling approximately $4,200,000 and $6,800,000 at June 30, 2016 and 2015, respectively.

Incurred losses identified through Regional One Health's incident reporting system and incurred but not reported losses are accrued based on estimates that incorporate Regional One Health's current inventory of reported claims and historical experience, as well as considerations such as the nature of each claim or incident, relevant trend factors, and advice from consulting actuaries.

The following is a summary of changes in Regional One Health's self-insurance liability for professional and general liability costs for fiscal 2016 and 2015:

		2016	2015
Balance at July 1	$	6,830,000	7,152,000
Provision for claims reported and claims incurred but not reported		(1,777,112)	179,580
Claims paid		(826,888)	(501,580)
		4,226,000	6,830,000
Amounts classified as accrued expenses and other current liabilities		(1,800,000)	(2,300,000)
Balance at June 30	$	2,426,000	4,530,000

Like many other businesses, Regional One Health is exposed to various risks of loss related to theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illness; and natural disasters. Commercial insurance coverage is purchased for claims arising from such matters. Claims settled through June 30, 2016 have not exceeded this commercial coverage in any of the three preceding years.

(Continued)

The following is a summary of changes in Regional One Health's self-insurance liability for employee health coverage (included in accrued expenses and other current liabilities in the accompanying balance sheets) for fiscal 2016 and 2015:

	2016	2015
Balance at July 1	$ 2,715,000	1,826,000
Claims reported and claims incurred but not reported	18,433,806	16,024,010
Claims paid	(18,340,806)	(15,135,010)
Balance at June 30	$ 2,808,000	2,715,000

(16) Commitments

Regional One Health has outstanding service contracts for management services, equipment maintenance, and blood supply services. Estimated future payments under the contracts follow:

2017	$ 3,712,864
2018	2,862,018
2019	2,415,295
2020	2,172,756
2021	1,519,940
Thereafter	1,294,327
	$ 13,977,200

Expense under these contracts and other contracts was approximately $13,700,000 and $11,800,000 for the years ended June 30, 2016 and 2015, respectively.

(17) Leases

Regional One Health has entered into noncancelable operating leases for certain buildings and equipment. Rental expense for all operating leases was approximately $5,300,000 and $5,200,000 for the years ended June 30, 2016 and 2015, respectively. The future minimum payments under noncancelable operating leases as of June 30, 2016 follow:

2017	$ 5,301,607
2018	4,725,940
2019	2,147,698
2020	1,756,670
2021	1,456,202
Thereafter	8,046,932
	$ 23,435,049

(Continued)

(18) Healthcare Industry Environment

Management at Regional One Health continually monitors economic conditions closely, both with respect to potential impacts on the healthcare provider industry and from a more general business perspective. Management recognizes that economic conditions may continue to impact Regional One Health in a number of ways, including uncertainties associated with U.S. healthcare system reform and rising self-pay and emerging high-deductible plan funded patient volumes coupled with increases in uncompensated care and decreasing reimbursement rates relative to governmental payors.

Schedule 1

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Combining Schedule – Statement of Net Position

June 30, 2016

Assets	Shelby County Health Care Corporation	Shelby County Health Care Properties, Inc.	Combined
Assets:			
Cash and cash equivalents	$ 16,657,356	52,694	16,710,050
Investments	111,841,180	—	111,841,180
Patient accounts receivable, net	64,422,437	—	64,422,437
Other receivables	13,662,415	149,000	13,811,415
Other current assets	6,432,834	849,337	7,282,171
Total current assets	213,016,222	1,051,031	214,067,253
Restricted cash	—	437,060	437,060
Restricted investments	6,062,721	—	6,062,721
Equity investments	12,980,671	—	12,980,671
Notes receivable	19,221,600	—	19,221,600
Capital assets, net	50,401,613	40,587,300	90,988,913
Total assets	$ 301,682,827	42,075,391	343,758,218
Liabilities and Net Position			
Liabilities:			
Accounts payable	$ 14,452,736	—	14,452,736
Accrued expenses and other current liabilities	44,379,028	148,822	44,527,850
Total current liabilities	58,831,764	148,822	58,980,586
Accrued professional and general liability costs	2,426,000	—	2,426,000
Obligation under reverse repurchase agreement	11,893,738	—	11,893,738
Net postemployment benefit obligation	960,000	—	960,000
Notes payable	—	26,550,000	26,550,000
Total liabilities	74,111,502	26,698,822	100,810,324
Net position:			
Invested in capital assets	50,401,613	14,037,300	64,438,913
Restricted for:			
Capital assets	1,896,509	—	1,896,509
Indigent care	702,167	—	702,167
Notes payable	—	437,060	437,060
Unrestricted	174,571,036	902,209	175,473,245
Total net position	227,571,325	15,376,569	242,947,894
Total liabilities and net position	$ 301,682,827	42,075,391	343,758,218

See accompanying independent auditors' report.

Schedule 2

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Combining Schedule – Statement of Net Position

June 30, 2015

Assets	Shelby County Health Care Corporation	Shelby County Health Care Properties, Inc.	Combined
Assets:			
Cash and cash equivalents	$ 9,716,806	47,353	9,764,159
Investments	109,959,639	—	109,959,639
Patient accounts receivable, net	68,627,756	—	68,627,756
Other receivables	10,819,415	149,000	10,968,415
Other current assets	5,983,237	1,052,482	7,035,719
Total current assets	205,106,853	1,248,835	206,355,688
Restricted cash	—	514,785	514,785
Restricted investments	6,901,313	—	6,901,313
Equity investments	10,999,876	—	10,999,876
Notes receivable	19,221,600	—	19,221,600
Capital assets, net	56,687,502	39,319,663	96,007,165
Total assets	$ 298,917,144	41,083,283	340,000,427
Liabilities and Net Position			
Liabilities:			
Accounts payable	$ 14,092,765	—	14,092,765
Accrued expenses and other current liabilities	38,169,476	148,200	38,317,676
Total current liabilities	52,262,241	148,200	52,410,441
Accrued professional and general liability costs	4,530,000	—	4,530,000
Net postemployment benefit obligation	750,000	—	750,000
Notes payable	—	26,550,000	26,550,000
Total liabilities	57,542,241	26,698,200	84,240,441
Net position:			
Invested in capital assets	56,687,802	12,769,663	69,457,465
Restricted for:			
Capital assets	2,855,282	—	2,855,282
Indigent care	834,684	—	834,684
Notes payable	—	514,785	514,785
Unrestricted	180,997,435	1,100,635	182,098,070
Total net position	241,375,203	14,385,083	255,760,286
Total liabilities and net position	$ 298,917,444	41,083,283	340,000,727

See accompanying independent auditors' report.

Schedule 3

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Combining Schedule – Statement of Revenues, Expenses, and Changes in Net Position

Year ended June 30, 2016

	Shelby County Health Care Corporation	Shelby County Health Care Properties, Inc.	Combined
Operating revenues:			
Net patient service revenue	$ 362,356,166	—	362,356,166
Other revenue	33,033,773	298,000	33,331,773
Total operating revenues	395,389,939	298,000	395,687,939
Operating expenses:			
Salaries and benefits	191,513,277	—	191,513,277
Supplies and services	93,353,541	—	93,353,541
Physician and professional fees	26,080,862	—	26,080,862
Purchased medical services	56,015,982	—	56,015,982
Plant operations	14,630,265	—	14,630,265
Insurance	422,542	—	422,542
Administrative and general	38,619,647	308,651	38,928,298
Community services	933,161	—	933,161
Depreciation	13,425,927	5,146,002	18,571,929
Total operating expenses	434,995,204	5,454,653	440,449,857
Operating loss	(39,605,265)	(5,156,653)	(44,761,918)
Nonoperating revenues (expenses):			
Interest expense	(132,398)	(265,500)	(397,898)
Investment income (loss)	3,066,749	—	3,066,749
Appropriations from Shelby County	27,408,000	—	27,408,000
Other	1,872,675	—	1,872,675
Transfers in (out)	(6,413,639)	6,413,639	—
Total nonoperating revenues (expenses), net	25,801,387	6,148,139	31,949,526
(Decrease) increase in net position	(13,803,878)	991,486	(12,812,392)
Net position, beginning of year	241,375,203	14,385,083	255,760,286
Net position, end of year	$ 227,571,325	15,376,569	242,947,894

See accompanying independent auditors' report.

Schedule 4

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)

Combining Schedule – Statement of Revenues, Expenses, and Changes in Net Position

Year ended June 30, 2015

	Shelby County Health Care Corporation	Shelby County Health Care Properties, Inc.	Combined
Operating revenues:			
Net patient service revenue	$ 347,134,962	—	347,134,962
Other revenue	25,941,916	298,000	26,239,916
Total operating revenues	373,076,878	298,000	373,374,878
Operating expenses:			
Salaries and benefits	179,221,725	—	179,221,725
Supplies and services	84,128,275	—	84,128,275
Physician and professional fees	25,475,185	—	25,475,185
Purchased medical services	44,448,420	—	44,448,420
Plant operations	13,783,854	—	13,783,854
Insurance	2,843,248	—	2,843,248
Administrative and general	34,498,576	247,462	34,746,038
Community services	757,581	—	757,581
Depreciation	13,527,554	4,677,433	18,204,987
Total operating expenses	398,684,418	4,924,895	403,609,313
Operating loss	(25,607,540)	(4,626,895)	(30,234,435)
Nonoperating revenues (expenses):			
Interest expense	(82,291)	(265,500)	(347,791)
Investment income	3,578,035	—	3,578,035
Appropriations from Shelby County	26,816,000	—	26,816,000
Other	8,729,084	1,075	8,730,159
Transfers in (out)	(3,869,244)	3,869,244	—
Total nonoperating revenues (expenses), net	35,171,584	3,604,819	38,776,403
Increase (decrease) in net position	9,564,044	(1,022,076)	8,541,968
Net position, beginning of year	231,811,159	15,407,159	247,218,318
Net position, end of year	$ 241,375,203	14,385,083	255,760,286

See accompanying independent auditors' report.

Schedule 5

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)
Combining Schedule – Statement of Cash Flows
Year ended June 30, 2016

	Shelby County Health Care Corporation	Shelby County Health Care Properties, Inc.	Combined
Cash flows from operating activities:			
Receipts from and on behalf of patients and third-party payors	$ 367,284,642	—	367,284,642
Other cash receipts	32,914,527	298,000	33,212,527
Payments to suppliers	(232,214,752)	(104,884)	(232,319,636)
Payments to employees and related benefits	(186,503,501)	—	(186,503,501)
Net cash (used in) provided by operating activities	(18,519,084)	193,116	(18,325,968)
Cash flows from noncapital financing activity:			
Appropriations received from Shelby County	25,328,013	—	25,328,013
Net cash provided by noncapital financing activity	25,328,013	—	25,328,013
Cash flows from capital and related financing activities:			
Capital expenditures	(13,661,497)	—	(13,661,497)
Interest payments	(124,420)	(265,500)	(389,920)
Net cash used in capital and related financing activities	(13,785,917)	(265,500)	(14,051,417)
Cash flows from investing activities:			
Purchases of investments	(300,665,214)	—	(300,665,214)
Proceeds from sale of investments	312,242,913	—	312,242,913
Investment income proceeds	2,339,839	—	2,339,839
Net cash provided by investing activities	13,917,538	—	13,917,538
Net increase (decrease) in cash and cash equivalents	6,940,550	(72,384)	6,868,166
Cash and cash equivalents, beginning of year	9,716,806	562,138	10,278,944
Cash and cash equivalents, end of year	$ 16,657,356	489,754	17,147,110

See accompanying independent auditors' report.

Schedule 6

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)
Combining Schedule – Statement of Cash Flows
Year ended June 30, 2015

	Shelby County Health Care Corporation	Shelby County Health Care Properties, Inc.	Combined
Cash flows from operating activities:			
Receipts from and on behalf of patients and third-party payors	$ 335,009,290	—	335,009,290
Other cash receipts	25,309,908	298,003	25,607,911
Payments to suppliers	(208,262,648)	(49,950)	(208,312,598)
Payments to employees and related benefits	(180,016,276)	—	(180,016,276)
Net cash (used in) provided by operating activities	(27,959,726)	248,053	(27,711,673)
Cash flows from noncapital financing activity:			
Appropriations received from Shelby County	26,816,000	—	26,816,000
Net cash provided by noncapital financing activity	26,816,000	—	26,816,000
Cash flows from capital and related financing activities:			
Capital expenditures	(11,893,966)	—	(11,893,966)
Proceeds from pledges	22,169	—	22,169
Proceeds from sale of capital assets	31,398	—	31,398
Interest payments	(82,291)	(269,625)	(351,916)
Net cash used in capital and related financing activities	(11,922,690)	(269,625)	(12,192,315)
Cash flows from investing activities:			
Purchases of investments	(238,329,755)	—	(238,329,755)
Proceeds from sale of investments	249,085,424	—	249,085,424
Investment in equity investees	(1,300,000)	—	(1,300,000)
Investment income proceeds	3,345,720	—	3,345,720
Net cash provided by investing activities	12,801,389	—	12,801,389
Net decrease in cash and cash equivalents	(265,027)	(21,572)	(286,599)
Cash and cash equivalents, beginning of year	9,981,833	583,710	10,565,543
Cash and cash equivalents, end of year	$ 9,716,806	562,138	10,278,944

See accompanying independent auditors' report.

Schedule 7

SHELBY COUNTY HEALTH CARE CORPORATION
(A Component Unit of Shelby County, Tennessee)
Roster of Management Officials and Board Members
June 30, 2016
(Unaudited)

Management Officials

Reginald Coopwood, M.D., President and CEO
Eric Benink, M.D., Senior Vice President/Chief Medical Officer
Pam Castleman, MSN, Senior Vice President/Chief Nursing Officer
Sarah Colley, Senior Vice President
Susan Cooper, RN, MSN, FAAN, Senior Vice President/Chief Integration Officer
Jackie Lucas, FACHE, Senior Vice President/CIO
Tammie Ritchey, CFRE, Vice President of Development/Foundation Executive Director
Robert Sumter, Ph.D., Executive Vice President/COO
Tish Towns, FACHE, Senior Vice President, External Relations
Rick Wagers, MBA, Senior Executive Vice President/CFO
Monica Wharton, ESQ, Senior Vice President/Chief Legal Counsel

Board Members

Ken Brown, Ph.D.
Pam Brown
Tyrone Burroughs
Ronald Coleman
Judy Edge
William D. Evans, Pharm.D.
James Freeman, M.D.
Brenda Hardy, M.D.
Edith Kelly-Green
Scot Lenoir
Scott McCormick
Commissioner Reginald Milton
David Popwell
Phil Shannon
John Vergos

See accompanying independent auditors' report.

Regional One Health - Extended Care Hospital

Statement of Revenue and Expenses
June 30, 2017
($ in Thousands)

	Month of June			Twelve Months Ending June 30		
	2017 Actual	2017 Budget		2016-17 Actual	2016-17 Budget	
1			**Patient Service Revenue**			1
2	$ 5,324	$ 4,922	Inpatient Revenue	$ 62,710	$ 59,171	2
3	-	-	Outpatient Revenue	-	-	3
4	$ 5,324	$ 4,922	**Gross Patient Service Revenue**	$ 62,710	$ 59,171	4
5			**Deductions from Revenue**			5
6	$ 3,172	$ 3,595	Contractual Adjustments	$ 48,430	$ 43,220	6
7	397	24	Charity Care	280	294	7
8	466	123	Provision for Bad Debts	599	1,479	8
6	$ 4,035	$ 3,742	**Total Deductions from Revenue**	$ 49,309	$ 44,993	6
7	$ 1,289	$ 1,180	**Net Patient Revenue**	$ 13,401	$ 14,178	7
8	$ -	$ -	**Other Operating Revenue**	$ -	$ -	8
9	$ 1,289	$ 1,180	**Net Revenue**	$ 13,401	$ 14,178	9
8			**Operating Expenses**			8
9	$ 511	$ 481	Salary Expense	$ 5,875	$ 5,873	9
10	109	107	Employee Benefits	1,019	1,288	10
11	210	183	Supplies	1,966	2,206	11
12	281	237	Other Expenses	2,720	2,842	12
13	20	14	Operation of Plant	238	166	13
14	86	72	Lease Expense	948	870	14
15	$ 1,217	$ 1,094	**Total Operating Expenses**	$ 12,767	$ 13,244	15
16	$ 72	$ 86	**Net Income**	$ 634	$ 934	16
			Volume			
17	607	630	Inpatient Days	7,378	7,574	17
18	16	21	Inpatient Discharges	192	255	18
19	37.9	30.0	Average Length of Stay	38.4	29.7	19
			Operational Indicators			
20	$ 8,771	$ 7,813	Gross Patient Revenue per Pat Day	$ 8,500	$ 7,812	20
21	$ 2,124	$ 1,873	Net Patient Revenue per Pat Day	$ 1,816	$ 1,872	21
22	$ 2,004	$ 1,737	Total Operating Exp per Pat Day	$ 1,730	$ 1,749	22
23	$ 1,022	$ 933	Salaries,Wages,Benefits per Pat Day	$ 934	$ 945	23
24	$ 346	$ 290	Supplies per Pat Day	$ 267	$ 291	24
25	$ 636	$ 513	Other Expenses per Pat Day	$ 529	$ 512	25
26	$ 332,749	$ 234,381	Gross Patient Revenue per Discharge	$ 326,614	$ 232,043	26
27	$ 80,561	$ 56,190	Net Patient Revenue per Discharge	$ 69,798	$ 55,599	27
28	$ 76,043	$ 52,095	Total Operating Exp per Discharge	$ 66,493	$ 51,937	28
29	$ 38,774	$ 28,000	Salaries,Wages,Benefits per Discharge	$ 35,910	$ 28,082	29
30	$ 13,123	$ 8,714	Supplies per Discharge	$ 10,242	$ 8,649	30
31	$ 24,145	$ 15,381	Other Expenses per Discharge	$ 20,342	$ 15,205	31

Regional One Health - Extended Care Hospital
Balance Sheet
June 30, 2017
($ in Thousands)

		June 2017
	Assets	
	Current Assets:	
1	Cash and Cash Equivalents	$ 4,680
2	Investments, market value	-
3	**Cash and Investments, net of Board Designated**	**4,680**
4	Patient Accounts Receivable-LTACH	17,092
5	Less Allowances for Contractual & Uncompensated Care-LTACH	(8,999)
6	**Patient Accounts Receivable, net-LTACH**	**8,093**
7	Other Accounts Receivable	-
8	Due from Affiliates	-
9	Prepaid Expenses	61
10	**Total Current Assets**	**12,834**
11	**Total Assets**	**$ 12,834**
	Liabilities & Fund Balance	
	Current Liabilities:	
12	Accounts Payable	$ 378
13	Accrued Expenses	408
14	Compensated Absences	202
15	Deferred Revenue	-
16	**Total Current Liabilities**	**988**
	Fund Balance:	
17	Revenue over (under) Expenses, Current Year	634
18	Unrestricted Fund Balance	11,212
19	**Total Liabilities & Fund Balance**	**$ 12,834**

Regional One Health - Extended Care Hospital

Statement of Revenue and Expenses
June 30, 2017
($ in Thousands)

	Month of June			Twelve Months Ending June 30		
	2017 Actual	2017 Budget		2016-17 Actual	2016-17 Budget	
1			**Patient Service Revenue**			1
2	$ 5,324	$ 4,922	Inpatient Revenue	$ 62,710	$ 59,171	2
3	-	-	Outpatient Revenue	-	-	3
4	$ 5,324	$ 4,922	**Gross Patient Service Revenue**	$ 62,710	$ 59,171	4
5			**Deductions from Revenue**			5
6	$ 3,172	$ 3,595	Contractual Adjustments	$ 48,430	$ 43,220	6
7	397	24	Charity Care	280	294	7
8	466	123	Provision for Bad Debts	599	1,479	8
6	**$ 4,035**	**$ 3,742**	**Total Deductions from Revenue**	**$ 49,309**	**$ 44,993**	6
7	**$ 1,289**	**$ 1,180**	**Net Patient Revenue**	**$ 13,401**	**$ 14,178**	7
8	$ -	$ -	**Other Operating Revenue**	$ -	$ -	8
9	**$ 1,289**	**$ 1,180**	**Net Revenue**	**$ 13,401**	**$ 14,178**	9
8			**Operating Expenses**			8
9	$ 511	$ 481	Salary Expense	$ 5,875	$ 5,873	9
10	109	107	Employee Benefits	1,019	1,288	10
11	210	183	Supplies	1,966	2,206	11
12	281	237	Other Expenses	2,720	2,842	12
13	20	14	Operation of Plant	238	166	13
14	86	72	Lease Expense	948	870	14
15	**$ 1,217**	**$ 1,094**	**Total Operating Expenses**	**$ 12,767**	**$ 13,244**	15
16	**$ 72**	**$ 86**	**Net Income**	**$ 634**	**$ 934**	16
			Volume			
17	607	630	Inpatient Days	7,378	7,574	17
18	16	21	Inpatient Discharges	192	255	18
19	37.9	30.0	Average Length of Stay	38.4	29.7	19
			Operational Indicators			
20	$ 8,771	$ 7,813	Gross Patient Revenue per Pat Day	$ 8,500	$ 7,812	20
21	$ 2,124	$ 1,873	Net Patient Revenue per Pat Day	$ 1,816	$ 1,872	21
22	$ 2,004	$ 1,737	Total Operating Exp per Pat Day	$ 1,730	$ 1,749	22
23	$ 1,022	$ 933	Salaries,Wages,Benefits per Pat Day	$ 934	$ 945	23
24	$ 346	$ 290	Supplies per Pat Day	$ 267	$ 291	24
25	$ 636	$ 513	Other Expenses per Pat Day	$ 529	$ 512	25
26	$ 332,749	$ 234,381	Gross Patient Revenue per Discharge	$ 326,614	$ 232,043	26
27	$ 80,561	$ 56,190	Net Patient Revenue per Discharge	$ 69,798	$ 55,599	27
28	$ 76,043	$ 52,095	Total Operating Exp per Discharge	$ 66,493	$ 51,937	28
29	$ 38,774	$ 28,000	Salaries,Wages,Benefits per Discharge	$ 35,910	$ 28,082	29
30	$ 13,123	$ 8,714	Supplies per Discharge	$ 10,242	$ 8,649	30
31	$ 24,145	$ 15,381	Other Expenses per Discharge	$ 20,342	$ 15,205	31

8500021350

AGREEMENT FOR THE PROVISION OF GRADUATE MEDICAL EDUCATION AT THE REGIONAL MEDICAL CENTER AT MEMPHIS

THIS AGREEMENT is made and entered into this 1st day of July, 2011, by and between the University of Tennessee and its College of Medicine (the "UNIVERSITY"), and The Shelby County Health Care Corporation d/b/a Regional Medical Center at Memphis ("The MED").

WITNESSETH

WHEREAS, the parties have operated under a master contract governing the provision of graduate medical education ("GME") at The MED for many years; and

WHEREAS, the UNIVERSITY'S educational programs are intended to provide Students and Residents with a variety of structured learning experiences, including the participation in patient care activities;

WHEREAS, the parties acknowledge the fact that high quality medical care for patients in a hospital setting is often associated with the participation of medical students and residents participating in accredited GME programs;

WHEREAS, both the UNIVERSITY and The MED will benefit from the participation of Students and Residents providing patient care at The MED under appropriate supervision from UNIVERSITY faculty physicians;

WHEREAS, the UNIVERSITY acknowledges the importance of The MED with respect to its overall GME Programs and intends to provide The MED with a decision making role in its consortium commensurate with The MED's importance as set forth in this agreement;

NOW, THEREFORE, in consideration of the mutual agreement and covenants of the parties and for other good valuable consideration, the parties agree as follows:

I. GENERAL INFORMATION-**It is understood and agreed that:**

A. The term "Resident" shall include House Staff, House Officers, and Fellows participating under the auspices of the University in a GME program approved or recognized by the Accreditation Council on Graduate Medical Education ("ACGME"). "Resident" shall include House Staff, House Officers, and Fellows participating under the auspices of the University in the Burn Fellowship or in Oral Surgery. The term "Student" shall refer to a person enrolled as an undergraduate in the College of Medicine.

B. It is understood by both parties that Students and Residents subject to this Agreement, while participating to any extent in patient care activities, will be permitted access to The MED premises for the exclusive purpose of medical training by the UNIVERSITY, as an adjunct to the patient care activities taking

place at the MED and its facilities and are not, by virtue of such actions, considered employees, agents, or servants of The MED for any purpose.

C. The UNIVERSITY is responsible for the control and supervision of the Students and Residents and acknowledges sole responsibility for directing all aspects of their medical education.

D. Throughout the term of this Agreement, Residents are employees of The State of Tennessee, of which the University is a part. Resident's salary and benefits are provided and paid by The UNIVERSITY or the State, although they will be reimbursed as provided herein below by The MED.

The UNIVERSITY Residents are covered as State employees under the provisions of the Tennessee Claims Commission Act (1985). Evidence of current malpractice coverage reflecting inclusive dates and limitations, if any, will be provided to The MED upon request.

II. TERMS OF PERFORMANCE

A. Resident Services

1. Staffing and Supervision:

a. The UNIVERSITY agrees to provide The MED with a house staff of GME Residents in accordance with the staffing levels and departmental distribution specified in Exhibit B. House staff, including all persons enrolled in GME programs through the UNIVERSITY, shall be referred to in this Agreement as "Residents." The UNIVERSITY shall be solely responsible for recruiting, designating, assigning and training Residents at The MED. The average number and general distribution of Residents assigned to The MED shall be negotiated annually by the Associate Dean for GME and the Chief Medical Officer as Exhibit B and shall be determined no later than May 1 for the academic year which begins the following July. Periodic review shall be at least quarterly or at the request of the Chief Medical Officer at The MED. The numbers last in effect will not be changed in subsequent years without the express agreement of The MED and the UNIVERSITY. In participating in the designation of number and distribution of Residents as set forth in this Paragraph The MED assumes no responsibility for the recruitment or training of the Residents, which shall remain the sole responsibility of the UNIVERSITY.

b. The UNIVERSITY shall provide or make arrangements for designating attending physicians, all of whom shall be faculty members of the UNIVERSITY, for general supervision, and direction of all Residents and Students at The MED, consistent with the applicable guidelines developed by State and Federal laws and/or accrediting agencies. Such supervision shall be as directed by the UTGME Supervision Policy as attached (Exhibit C). The number of faculty attending physicians shall be based upon an

established ratio of faculty to housestaff for the particular department as set forth in Exhibit B.

c. In all cases the GME supervision ratio of faculty at The MED shall not be less than one faculty member per four residents.

d. Patient care and treatment shall be provided by Residents only under the supervision and direction of attending physician Faculty. Nothing in this Agreement shall be construed as assigning Residents to act on behalf of or under the direction of The MED.

B. Training Program.

1. Medical Staff Membership. Faculty shall be members of Medical Staff and subject to, and bound by, all applicable medical staff and Hospital policies of The MED. The UNIVERSITY shall be responsible for notifying its personnel of The MED's policies applicable to their job responsibilities and shall cooperate with The MED's training programs designed to instruct staff regarding The MED's policies.

2. Faculty Appointments. The MED's medical staff members must be appointed to the faculty of the UNIVERSITY College of Medicine in order to be on the Training Program teaching staff at The MED. Any faculty appointments shall be made by the UNIVERSITY College of Medicine in accordance with its established policies.

3. Cost of Resident Service. The UNIVERSITY shall pay for or provide all resident salaries, health benefits, workers compensation benefits, applicable taxes and all other reemployment related benefits or expenses.

4. MED Payment of Resident Costs. The UNIVERSITY shall bill The MED for Resident costs on a monthly basis in accordance with the provisions of Paragraph II. D. 9. This payment and all funds provided to the University under this Agreement are for the exclusive purpose of providing GME.

5. Accreditation of Teaching Program. The UNIVERSITY is responsible for maintaining accreditation of medical education and training programs implemented (in whole or in part) at The MED. The MED shall cooperate with and assist the UNIVERSITY in maintaining such accreditation, as provided for in this Agreement.

6. Documentation. The UNIVERSITY agrees to provide such documentation as is reasonably required by The MED to verify support of GME residents and Faculty. The methodology utilized by the UNIVERSITY is subject to the approval of The MED.

C. Research

The MED recognizes and agrees that, as a part of its role as a teaching hospital, it will be the location of research projects involving both inpatients and outpatients. The MED agrees to make its patients available for such research and to make its staff and equipment available to support such research under the condition that any research grant application undertaken by UNIVERSITY which requires participation in, or contribution to, patient access, space availability or other MED resource allocation, will be submitted to The MED'S CMO for approval. This function will be carried out concurrently with IRB review and shall not

delay submission of the application to the outside agency. The parties further agree that UNIVERSITY will include in its Research Grant proposals expenses which The MED would incur for use of staff, equipment and facilities if the study is conducted at The MED. The University will advise The MED of Grants awarded. University will reimburse The MED for expenses incurred for laboratory tests, radiological studies, and all other procedures required by study protocols or contracts at a mutually agreed rate. Unless otherwise agreed to, clinical research studies conducted by the UNIVERSITY at The MED are governed by a Clinical Research Agreement between the parties dated October 22, 2007.

D. The MED.

1. The MED shall, at its own expense, own, maintain and operate the Hospital with qualified and adequate personnel, and provide sufficient supplies, equipment, and facilities in order to maintain a hospital in compliance with the accreditation standards of The Joint Commission ("TJC"), ACGME, and any other applicable accrediting and regulatory bodies, and in conformity with all applicable state and federal laws, rules, regulations and standards.
2. The MED shall cooperate with the UNIVERSITY to maintain teaching or education accreditation standards within their control, and notify the UNIVERSITY within 15 days of such time as The MED has knowledge of matters which may compromise educational program accreditation. Any such notice shall be given in writing, delivered only to the UNIVERSITY's Office of Graduate Medical Education, and shall be handled in such a manner as to preserve such privileges as may be available under applicable law, including but not limited to peer review privilege.
3. The MED shall include UNIVERSITY personnel in training programs regarding medical staff Hospital policies, and shall cooperate with the UNIVERSITY in instructing UNIVERSITY personnel regarding medical staff Hospital policies.
4. The MED will provide the physical facilities and other equipment necessary for the clinical educational experiences of Residents and Students as agreed upon by both parties.
5. The MED will provide opportunities for Residents and Students to have satisfactory training experiences commensurate with the standards for Liaison Committee on Medical Education ("LCME") accredited medical schools and ACGME accredited programs.
6. The MED agrees to provide appropriate call quarters including providing the availability of food for Residents and Faculty supervising physicians on call and agrees to provide parking facilities for Residents, and Faculty supervising physicians assigned to The MED. The MED agrees to take reasonable precautions to provide a safe environment for Residents.
7. The MED shall permit Residents to have (a) access to patients as designated or assigned to them by their supervising Faculty attending

physicians, (b) access to the charts of those patients assigned, and (c) access to and use of clinical information retrieval systems within The MED.

8. The MED through its Chief Medical Officer may suspend patient care responsibilities or otherwise exclude from the Hospital any Resident or Student who fails to adhere to The MED's policies, procedures and quality expectations, subject to final resolution of any such individual's status by The MED and the UNIVERSITY. The UNIVERSITY shall provide replacement services to The MED for any Resident suspended or excluded hereunder, if available. The UNIVERSITY retains the sole right and responsibility for discipline and/or termination of residents.

9. The MED agrees to compensate the UNIVERSITY on a monthly basis upon receipt of an invoice from UNIVERSITY for the Residents and faculty supervision of Residents in accordance with fixed amounts, set in advance and agreed upon in writing by the parties and attached as an amendment to this Agreement (Exhibits A & B). The fixed amount shall include any compensation of the Residents' salary and benefits and any associated administrative costs mutually agreed upon by the parties (Exhibit A).

10. The MED shall provide baseline medical treatment and care to any Resident, for any injury incurred on the job, including without limitation, source-patient testing or screening as appropriate, with transfer of the Resident's medical records necessary for such Resident to receive subsequent care through the UNIVERSITY health care benefits program, which shall assume full Workers' Compensation responsibility for any injury related to an occurrence in the work place. The MED is not responsible for medical care for Residents except this first aid.

11. The MED shall provide certain on-duty benefits to Residents as established by the GME Committee.

E. The UNIVERSITY

1. The UNIVERSITY shall perform the responsibilities of a LCME accredited College of Medicine. This responsibility includes the exclusive control of the education and evaluation of Students.

2. The UNIVERSITY shall perform the responsibilities as the institutional sponsor of the Graduate Medical Education Program as described in the "Essentials of Accredited Residencies" published by ACGME. This includes the establishment and maintenance of a Graduate Medical Education Committee ("GMEC") which meets at least quarterly and whose membership shall include representation of the major affiliated institutions, appropriate UNIVERSITY administrators, and peer selected residents. After consultation with each hospital that has a Major Affiliation Agreement with the College of Medicine, the dean of the College of Medicine shall appoint a representative of that hospital to the GME Committee. The GMEC Chair and/or the UNIVERSITY's Designated Institutional Official ("DIO") shall present an annual report to the appropriate committees of the Medical Staff of The MED, reviewing

the activities of the GMEC as required by the ACGME Institutional Requirements. The GMEC and The appropriate Medical Staff committees of The MED shall have the opportunity to regularly communicate about the patient safety and quality of patient care provided by the Residents.

3. The UNIVERSITY shall centralize records and institutional administrative support for all approved medical education programs in the Office for Academic Affairs for Students and the Office of Graduate Medical Education for Residents. This shall include but not be limited to: a) maintenance of master records of all Residents and Students assigned to The MED, including information necessary for certification, scheduling and rotation; b) payroll and fringe benefits administration; c) the provision of central payroll function for paychecks of all Residents assigned to The MED; and d) monitoring of Resident Agreements and payroll forms.
4. The UNIVERSITY shall invoice The MED monthly for its pro rata share of Resident costs on a regular basis, including salary, FICA, fringe benefits, and any administrative costs in accordance with Paragraph II. D. 9.
5. The UNIVERSITY shall establish appropriate policies and procedures to govern GME programs in compliance with ACGME and have these policies available on the GME website for all residents and participating institutions.
6. The UNIVERSITY shall determine the qualifications for, interview, and accept all Students in the College of Medicine. The UNIVERSITY shall determine the qualification for, recruit, select, and appoint all Residents in the GME program.
7. In compliance with TJC standards, the UNIVERSITY shall make available on the GME website a listing of all Residents and the procedures that the Resident can perform without supervision. In addition, the UNIVERSITY shall provide adequate communication resources and technological support, at a minimum through computer and internet access for the DIO, GME staff, and personnel, Program Directors, faculty, Residents and The MED.
8. The UNIVERSITY shall assure compliance with Tennessee Medical Board licensure requirements for Residents.
9. The UNIVERSITY will assign Residents and Students to The MED on a rotating basis. Such assignments will be made by the Office of Academic Affairs through the individual clerkship directors for students and the respective program directors for Residents.
10. The UNIVERSITY will remove a Student or Resident from the clinical experiences at The MED at the request of The MED if the Resident's or Student's behavior and conduct are inappropriate. This shall be consistent with the provisions of Paragraph II D.8. of this Agreement.
11. The UNIVERSITY faculty will be responsible for the supervision and control of Residents and Students at The MED. Faculty members will be responsible for providing supervision according to UNIVERSITY polices

and/or LCME/ACGME, or other appropriate practice specialty guidelines. Faculty members will be responsible for providing attending and consultative services for all unassigned patients of The MED in accordance with the privileges granted to them under the Medical Staff By-Laws.

12. Faculty will supervise the education of Residents and delivery of patient care services associated with GME activities at The MED, serve as attending and consultative physicians in accordance with the Medical Staff Bylaws of The MED, and provide for appropriate documentation of treatment to patients personally or through documentation provided by Residents.
13. The Office of Graduate Medical Education shall report to The MED on a periodic basis the Residency Review Committee accreditation status and the results of an annual or their periodic survey of Residents seeking feedback from Residents as to their satisfaction with the UNIVERSITY's training programs at The MED's facilities.
14. The UNIVERSITY shall assist in preparation of data and scheduling of site visits for accreditation of Training Programs by the ACGME and other official accreditation bodies.
15. The UNIVERSITY shall prepare, on behalf of the Program Director of each Training Program, certificates indicating satisfactory completion by a Resident of training years.

III. COORDINATION OF GME ACTIVITIES

A. The primary UNIVERSITY representative for the day to day management of this Agreement will be the Associate Dean for GME for Resident issues and the Associate Dean for Academic Affairs for Student issues.

B. The primary MED representative for the day to day management of this Agreement will be the Chief Medical Officer ("CMO").

C. Dispute Resolution will be addressed by the Chancellor of the University of Tennessee Health Sciences Center and Chief Executive Officer for The MED and follow the procedure set forth in Paragraph VI. Y. below.

D. The MED's CMO will monitor Resident rotation schedules monthly to assure compliance with the annual Resident GME budget, rotation assignment plan and UTGME Supervision Guidelines. In conjunction with this review of the rotation schedule assignments, the GME office will track the actual level of faculty physician supervision provided as compared to the level budgeted.

E. Based upon the above monitoring, if the amount of Resident/faculty supervision services provided is less than the amount budgeted the overpayment will be rebated to The MED. Variances from the established budget will be monitored and reconciliations made on not less than a quarterly basis.

IV. TERM AND TERMINATION

A. Effective Date. The effective date of this Agreement shall be July 1, 2011.

B. Term. The term of this Agreement shall be five (5) years, beginning on the effective date of this Agreement and ending June 30, 2016. As ACGME requires

all hospital agreements to be no more than five years old, this Agreement cannot be extended for additional time beyond 2016.

C. Termination.

1. For Convenience. This Agreement may be terminated without cause by any party by the provision of at least 365 days prior written notice to the other parties.

2. Upon Material Change. In the event of a change or changes in the health care regulatory or reimbursement environment which could reasonably be expected to substantially deprive any party of one or more of the material benefits contemplated by this Agreement, then the parties shall, within fifteen (15) calendar days following notice from one party to the other of the occurrence of such a change begin negotiations in good faith to amend this Agreement as necessary to restore the parties to a mutually beneficial relationship under this Agreement. In the event such negotiations fail to produce, within thirty (30) days following the original written notice of the occurrence this Agreement may be terminated by either party upon an additional sixty (60) days written notice to the other party.

Agency UT

V. INDEMNIFICATION

Each party to this Agreement agrees that if it is found to be without direct fault through the acts or omissions of its employees ~~or agents,~~ and is held liable for the acts or omissions of the other party's employees ~~or agents~~ solely arising out of their failure to provide medical care in accordance with the recognized standard of professional practice, its rights of contribution or indemnity as provided by the applicable laws for the State of Tennessee may be pursued in accordance with such laws. Further, each party agrees that the exclusive remedy for claims against the University under this section, if it accepts such jurisdiction, lies in the Tennessee Claims Commission. The liability of The MED (and its obligation to indemnify) is subject to the provisions of the Governmental Tort Liability Act, T.C.A. 29-20-101 *et. seq.*, and nothing in this Agreement shall be considered as extending or expanding the limitations on recovery allowed under actions brought against The MED that would otherwise be covered under that statute. ~~Notwithstanding the foregoing, to the extent any claims are brought against The MED for the acts or omissions of a Resident or Student under this Agreement under any theory of liability, including but not limited to, under the theory of actual or apparent agency, and including as well allegations of negligent supervision, then the University shall hold harmless The MED for such claims, and agrees to reimburse The MED for reasonable attorneys' fees and costs it incurs in defending said claims.~~ University's liability is governed by Tennessee Claims Commission Act 9-8-301.

Agency UT

Agency UT

VI. MISCELLANEOUS

A. Confidentiality.

1. Patient Records. The Parties shall maintain the confidentiality of all patient records and shall comply with all applicable federal, state, and local laws and regulations, Hospital and Medical Staff By-Laws, policies, and procedures regarding the confidentiality of medical records.

2. Privileged Information. Each party shall maintain the confidentiality of all information provided by any other party to which legal privilege may

apply. Each Party shall disclose privileged information only to personnel under its supervision and only on an as-needed basis consistent with applicable law. All personnel of each Party shall be bound by the provisions of this Section, and each Party shall be responsible for informing personnel under its supervision of these requirements, as appropriate. No party shall be in breach of this Section solely by reason of its compliance with federal, state, or local law requiring disclosure of privileged information, provided that prior to any such disclosure such Party shall notify the other Party in writing of its intent to disclose such information, and shall permit the other Party a meaningful opportunity to assert any applicable privilege.

B. Risk Management and Quality Assurance. The Parties shall cooperate in risk management and quality assurance activities and shall exchange information for risk management and quality assurance purposes. Provided, however, nothing contained herein shall be construed as abrogating the attorney-client privilege or otherwise adversely affect the attorney-client relationship or any quality assurance/peer review activity, and provided further that each party shall take all reasonable steps to preserve any such applicable privilege.

C. Maintenance of Funding for GME. The Parties will work diligently to maintain Graduate Medical Education funding from state and federal sources. Any state or federal GME funds paid to the UNIVERSITY will be transferred to The MED based on annual negotiations.

D. Independent Contractor. In the performance of this Agreement, the UNIVERSITY and The MED are at all times acting as independent contractors. No party shall have or exercise control over the specific methods by which the other perform their duties under this Agreement.

E. Assignment and Subcontracting. This Agreement shall be binding and to the benefit of the Parties and their respective successors and assigns; provided, however that no Party my assign any of its interests, rights or obligations under this Agreement without the prior written consent of the other Party. No Party may subcontract for the performance of any of these duties under this Agreement without the prior written consent of the other Party. This provision shall not limit the right of any Party to engage individuals who may perform services under this Agreement; however each Party shall remain fully responsible for its performance as provided in this Agreement.

F. No Third Party Beneficiaries. None of the provisions of this Agreement are or shall be construed as for the benefit of or enforceable by any person not a Party to this Agreement.

G. Modification. This Agreement constitutes the entire agreement of the Parties with respect to its Resident and GME Services, and supersedes all prior agreements, representation, or communication, oral or written, relating thereto. This Agreement may not be modified except by a written amendment properly approved and executed by all Parties.

H. Waiver. No waiver, express or implied, of any breach of this Agreement shall constitute a waiver of any right under this Agreement or of any subsequent breach, whether of a similar or dissimilar nature.

I. HIPAA. The MED and the UNIVERSITY shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164 Privacy and Security Laws as may be amended from time to time.

J. Severability. If any provision of this Agreement shall be unenforceable for any reason, the remaining portions shall remain in force and effect; provided, however, that if the removal of any such provision has the effect of materially altering the obligation of any Party so as to cause serious hardship to such Party or to cause such Party to act in violation of its Articles of Incorporation the party so affected shall have the right to terminate this Agreement upon thirty (30) days written notice to the other Party.

K. Governing Law. The Agreement shall be governed by the law of the State of Tennessee.

L. Related Parties and Subcontractor Requirements. Each party shall, upon proper request, allow the United States Department of Health and Human Services, the Comptroller General of the United States, the Tennessee Department of Health, the Tennessee Department of Finance and Administration, and their duly authorized representatives access to this Agreement and to all books, documents, and records necessary to verify the nature and extent of the costs of services provided by any party under this Agreement, at any time during the term of this Agreement and for an additional period of five (5) years following the last date services are furnished under this Agreement. If any party carries out any of its duties under this Agreement through an agreement between its and an individual or organization related to it, that party to this Agreement shall require that a clause be included in such agreement to the effect that until the expiration of five (5) years after the furnishing of services pursuant to such agreement, the related organization shall make available, upon request to the United States Department of Health and Human Services, the Comptroller General of the United States, the Tennessee Department of Health, the Tennessee Department of Finance and Administration, and their duly authorized representatives access to this Agreement and to all books, documents, and records necessary to verify the nature and extent of the costs of services provided by any party under this Agreement.

M. Equal Opportunity. The parties shall abide, to the extent applicable thereto, by the provisions of Titles VI and VII of the Civil Rights Act of 1964 (42 U.S.C. Sec. 2000e et seq., as amended), which prohibits discrimination against any employee or applicant for employment or recipient of services on the basis of race, religion, color, sex or national origin. The parties further agree to abide by Executive Order No. 11246, as amended, which prohibits discrimination on the basis of sex; the Age Discrimination in Employment Act, 29 U.S.C. Sec. 621 et seq., as amended, and 45 C.F.R. 90, which prohibits discrimination on the basis of age; Section 5045 of the Rehabilitation Act of 1973, 29 U.S.C. Sec. 701 et seq., which prohibits discrimination on the basis of handicap; and the Americans with Disabilities Act, 42 U.S.C. Sec. 12101 et seq., and 29 C.F.R. 1630, which provides that no qualified individual with a disability, by reason of such disability, shall be denied employment, excluded from participation in, or denied the benefits of services, programs or activities.

N. Binding Effect Upon Successors. This Agreement shall be binding upon and inure to the benefit of the parties and their respective heirs, executors, administrators, successors, legal representatives and assigns; provided that this provision shall not be construed as permitting assignment, substitution, delegation or other transfer of rights or obligations except strictly in accordance with the other provisions of this Agreement.

O. Integration. This Agreement constitutes the entire agreement between the parties pertaining to the subject matter hereof, and supersedes all prior agreements and understandings pertaining thereto. No covenant, representation or condition not expressed in this Agreement shall affect or be deemed to interpret, change or restrict the express provisions hereof unless reduced to writing and signed by both parties.

P. Exhibits, Etc. All exhibits and other documents attached to or to be delivered in connection with this Agreement are expressly made a part of this Agreement.

Q. Further Assurances. The parties shall execute and deliver all documents, provide all information and take or forbear from any action that may be reasonably necessary or appropriate to achieve the purposes of this Agreement.

R. Authorization. Each individual executing this Agreement does thereby represent and warrant to each other person so signing (and to each other entity for which another person may be signing) that he or she has been duly authorized to execute this Agreement in the capacity and for the entity set forth above such person's signature.

S. Execution by Counterpart. This Agreement may be executed separately or independently by the parties in counterpart, each of which together shall be deemed to have been executed simultaneously and for all purposes to be one instrument.

T. Force Majeure. Neither party shall incur any liability to the other party, nor shall either party be entitled to terminate this Agreement, if the performance by either party of its obligations under this Agreement is prevented or delayed by act of God, the public enemy, earthquakes, fires, epidemics, civil insurrections, curtailment of or failure to obtain sufficient electrical power, strikes, lockouts or similar unforeseen and unusual circumstances beyond the control and without the fault of such party. Any party claiming any such excuse for non-performance shall use its best efforts to avoid or remove such cause, shall continue performance to the degree possible and as soon as possible, and shall give prompt written notice to the other party of the situation.

U. Compliance with Applicable Laws. The parties shall comply with all applicable statutes, laws, rules, regulations, licenses, certificates and authorizations of any governmental body or authority in the performance of its obligations under this Agreement. This Agreement shall be subject to amendments to applicable laws and regulations relating to the subject matter hereof, but to the extent that any inconsistency is thereby created, the parties shall used their best efforts to accommodate the terms and intent of this Agreement and of such amendments. Each party shall obtain and maintain current and in force all licenses, certifications, authorizations and permits (and shall pay the fees therefor) required to carry out its obligations under this Agreement.

V. Notices. Unless otherwise specified in this Agreement, any notice, document, or other communication given, or made hereunder shall be sufficient in writing and shall be deemed given upon (a) hand delivery, (b) transmission by facsimile and oral confirmation of receipt, (c) deposit of the same in the United States registered or certified mail, first class postage and fee prepaid, and correctly addressed to the party for whom it is intended at the following addresses:

If to The MED:	Chief Medical Officer Regional Medical Center at Memphis 877 Jefferson Avenue Memphis, TN 38103
	Chief Legal Officer and General Counsel Regional Medical Center at Memphis 877 Jefferson Avenue Memphis, TN 38103
If to the UNIVERSITY:	Associate Dean GME 910 Madison Avenue Suite 1031 Memphis, TN 31863

Or at such other place or places as shall from time to time be specified in a notice similarly given. Each Party shall promptly notify the other Parties of any change of address.

W. Nondiscrimination. The parties hereto agree not to discriminate against any individual on account of race, relation, national origin, or handicap unrelated to the reasonable requirements of this Agreement.

X. Section Headings. Section Headings are for convenience only and shall not be construed as part of this Agreement.

Y. Dispute Resolution. Any controversy, dispute, or disagreement arising out of or related to this Agreement or the breach of this Agreement shall be settled in accordance within this provision. In the event a dispute arises between the parties, each party shall be obligated to meet and confer with the other in good faith, on reasonable notice and at a mutually agreeable location. The parties agree that if either party refused to participate in such a conference, or if such a conference fails to produces a mutually acceptable resolution of the dispute within a mutually acceptable time, either party may submit the matter to mediation. Such mediation will occur upon consent of the parties which consent may be withdrawn at any time.

Z. Compliance. The parties enter into this Agreement with the intent of conducting their relationship in full compliance with applicable state, local and federal law, including the Medicare/Medicaid anti-kickback/Fraud and Abuse provisions and the Stark Law. Notwithstanding any unanticipated effect of any provisions herein, neither party will intentionally conduct itself under the terms of this Agreement in a manner to constitute a violation of said statutes. UNIVERSITY agrees to cooperate fully with compliance efforts of THE MED designed to

comply with applicable federal and/or state statutory and regulatory requirements in accordance with THE MED's compliance plan, including, but not limited, adherence to the THE MED's Code of Conduct.

IN WITNESS WHEREOF, the parties have entered into this Agreement as of the day and year first state above.

University of Tennessee
Anthony A Ferrara
Vice Chancellor, Finance and Operations

6.20.11
Date

Regional Medical Center
Reginald Coopwood, MD
Chief Executive Officer

6/17/2011
Date

Exhibit B - FY12
Supervision of Housestaff

January 12, 2011

Department	Speciality	# Residents	Faculty to Resident Ratio	# Faculty Supervising	AAMC Rate	Benefits at 30%	Annual Cost at 70%
Medicine	Allergy/Immunology	0.0	0.500	0.000	142,000.00	184,600.00	$ -
"	Cardiology	3.0	0.500	0.250	251,000.00	326,300.00	$ 57,102.50
"	Dermatology	2.0	0.500	1.000	223,000.00	289,900.00	$ 202,930.00
"	Endocrinology	1.0	0.500	0.250	149,000.00	193,700.00	$ 33,897.50
"	Gastroenterology	2.0	0.500	0.750	232,000.00	301,600.00	$ 158,340.00
"	Gen Internal Medicine	26.0	0.333	8.666	165,000.00	214,500.00	$ 1,301,199.90
"	Hematology/Oncology	1.0	0.500	0.250	206,000.00	267,800.00	$ 46,865.00
"	Infectious Disease	1.0	0.250	0.250	153,000.00	198,900.00	$ 34,807.50
"	Nephrology	1.0	0.500	0.500	180,000.00	234,000.00	$ 81,900.00
"	Pulmonology	3.0	0.500	0.500	185,000.00	240,500.00	$ 84,175.00
"	Rheumatology	1.0	0.500	0.250	155,000.00	201,500.00	$ 35,262.50
Neurology	Neurology	3.0	0.250	0.750	173,000.00	224,900.00	$ 118,072.50
Neurosurgery	Neurosurgery	3.0	0.250	1.250	445,000.00	578,500.00	$ 506,187.50
OB/GYN	OB/GYN	31.0	0.250	7.250	241,000.00	313,300.00	$ 1,589,997.50
Ophthalmology	Ophthalmology	2.5	0.250	0.630	235,000.00	305,500.00	$ 134,725.50
Orthopaedics	Orthopaedics	14.0	0.250	3.500	372,000.00	483,600.00	$ 1,184,820.00
Otolaryngology	Otolaryngology	2.0	0.250	0.500	283,000.00	367,900.00	$ 128,765.00
Dentistry	Oral Surgery*	3.0	0.250	0.000	-	-	$ 239,585.00
Pathology	Pathology	0.0	0.250	0.000	185,000.00	240,500.00	$ -
Pediatrics	Pediatrics	6.0	0.250	1.250	176,000.00	228,800.00	$ 200,200.00
Pediatrics	Neontology	3.0	0.250	1.250	-	-	$ -
Psychiatry	Psychiatry	3.0	0.250	0.750	143,000.00	185,900.00	$ 97,597.50
Radiology	Radiology	4.0	0.250	1.000	327,000.00	425,100.00	$ 297,570.00
Surgery	Surgery	20.0	0.250	3.750	303,000.00	393,900.00	$ 1,033,987.50
Surgery	Plastics Surgery	3.0	0.250	0.250	353,000.00	458,900.00	$ 80,307.50
Surgery	Critical Care Surgery	2.0	0.250	0.500	313,000.00	406,900.00	$ 142,415.00
Urology	Urology	2.0	0.250	0.500	303,000.00	393,900.00	$ 137,865.00
		142.5		35.796			$ 7,928,575.40

Rates reflect 2008 AAMC Associate Professor 50%ile, Southern Region. All Region data used when regional data not present.

* Assumes rate from previous schedules

MED

UT

RESIDENT SUPERVISION

PROGRAM LETTERS OF AGREEMENT

In order to ensure residents receive appropriate educational experience under adequate supervision, a Program Letter of Agreement (PLA) will be updated and signed annually by the program director and site director for each participating site providing a required program assignment. The PLA will include the following information:

- identify faculty name/or general faculty group who teaches/supervises residents;
- specify their responsibilities for teaching, supervision, and formal evaluation of residents;
- specify the duration and content of the educational experience; and
- state that residents must abide by the policies of the site, the program, and the GMEC.

A copy of the PLA will be sent to and maintained in the GME office.

Individual programs must have specialty-specific supervision policies. Listings of procedural competencies by resident name and by program can be accessed on the GME Resident Supervision web page.

INSTITUTIONAL POLICY ON RESIDENT SUPERVISION

The following resident supervision policy has been approved by the Dean of the College of Medicine: http://www.uthsc.edu/GME/supervision.php. Development criteria were to promote patient safety, provide educational excellence, but maintain autonomy based on demonstrated education competence. The policy is effective in all training sites without regard to patient insurance status or time of day. Residents and faculty members in training programs under the auspices of ACGME will abide by the supervision and documentation schema as noted below.

University of Tennessee Graduate Medical Education Resident Supervision Policy

	Resident Activity	Resident Activity Description of Supervision		Documentation of Supervision Minimum Level*
A.	INPATIENT CARE	New Admission	Residents will notify departmental attending physician upon patient admission. The urgency of notification is based upon severity and acuity of patient. The departmental attending physician must see and evaluate the patient within one calendar day of admission.	Level # 2, Co-signature not sufficient

	Continuing Care	Departmental attending physician is personally involved in ongoing care.	Level #4
	Intensive Care	Because of the unstable nature of patients in ICUs, involvement of departmental attending physician is expected on admission and at least on a daily basis.	Level #4
	Hospital Discharge/ Transfer	The departmental attending physician must be involved in decision to discharge or transfer patient.	Level # 3 Discharge Summary Signature or Transfer Note Co-signature

B.	OUTPATIENT CARE	New Patient Visit	The departmental attending physician must be present in the clinic. Every new patient must be seen by and/or discussed with the departmental attending physician.	Level # 2, Co-signature not sufficient
		Return Patient Visit	The departmental attending physician must be present in the clinic.	Level #4
		Clinic Discharge	The departmental attending physician will assure clinic discharge is appropriate.	Level #4

C.	OPERATING / DELIVERY ROOM	The departmental attending physician must be notified prior to the scheduling of the procedure.	The departmental attending physician must physically be present, within the facility where the procedure occurs, for the major components of the procedure and degree of involvement documented.	Level A: Attending performing the procedure, assisted by resident Level B: Resident performing the procedure and the departmental attending physician is scrubbed Level C: Resident performing the procedure with the departmental attending physician not scrubbed, but present in Operating Room

				Level D: Resident performing the procedure with the departmental attending physician not scrubbed, but present in suite or facility Level E: Emergency Care – immediate care is initiated to preserve life or prevent impairment. The procedure is initiated with the departmental attending physician contacted and in route
D.	CONSULTATIONS (Inpatient, Outpatient and Emergency Department)	Departmental attending physician must supervise all consults.		Level #4 consistent with patient's condition and principles of graduated responsibility.
E.	RADIOLOGY/ PATHOLOGY			All reports verified by departmental attending physician prior to release
F.	EMERGENCY DEPARTMENT	Assigned Emergency Department Attending physician must be present in the emergency department and is the attending of record. Assigned Departmental attending physician must be involved in disposition of all patients. Patients to be admitted are then assigned to clinical Department Attending (see A.).		Level #4 consistent with patient's condition and principles of graduated responsibility.
G.	ROUTINE BEDSIDE & CLINIC PROCEDURES			Level #4 consistent with patient's condition and principles of graduated responsibility as outlined on GME supervision web site http://www.uthsc.edu/GME/supervision.php.

H.	NON-ROUTINE, NON-BEDSIDE, NON-OR PROCEDURES	(e.g., Cardiac Cath, endoscopy, interventional radiology, etc)	The departmental attending physician must physically be present within the facility where the procedure occurs, for the major components of the procedure and degree of involvement documented.	Level A: Attending performing the procedure, assisted by resident Level B: Resident performing the procedure and the departmental attending physician is assisting Level C: Resident performing the procedure with the departmental attending physician not assisting, but present in suite. Level D: Resident performing the procedure with the departmental attending physician not assisting, but present in suite or facility. Level E: Emergency Care – immediate care is initiated to preserve life or prevent impairment. The procedure is initiated with the departmental attending physician contacted and in route.

Level of Supervision Documentation

1. Departmental attending physician Note

2. Departmental attending physician Addendum to the resident's note (not a co-signature)

3. Departmental attending physician Co-signature implies that the departmental attending physician has reviewed the resident's note, and absent an addendum to the contrary, concurs with the content of the resident's note.

4. Resident Documentation of departmental attending physician supervision. (e.g., "I have seen and/or discussed the patient with my departmental attending physician, Dr. "X," who agrees with my assessment and plan.")

Board for Licensing Health Care Facilities

State of Tennessee

0000000186

No. of Beds 0024

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

REGIONAL MED EXTENDED CARE HOSPITAL, LLC *to conduct and maintain a*

Hospital REGIONAL ONE HEALTH EXTENDED CARE HOSPITAL

Located at 890 MADISON AVENUE, 4TH FLOOR, MEMPHIS

County of SHELBY *, Tennessee.*

This license shall expire DECEMBER 02 , 2017 , *and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 1ST *day of* NOVEMBER , 2016 .

In the Distinct Category(ies) of: CHRONIC DISEASE HOSPITAL
PEDIATRIC BASIC HOSPITAL

By Vincent J. Davis, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By [signature]
COMMISSIONER

DCF011

167 Attachment B.OrderlyDevelopment.D.1.

Regional One Health
EXTENDED CARE

March 3, 2017

Kathy Zeigler, RN
Department of Health
West Tennessee Health Care Facilities
2975 C Highway 45 Bypass
Jackson, TN 38305-3608

VIA: Federal Express

Re: Regional One Health Extended Care Hospital Life Safety Plan of Correction Response

Dear Ms. Kathy Zeigler,

Please accept this letter and enclosed documentation on behalf of Regional One Health Extended Care Hospital in response to correspondence received from your office dated February 23, 2017. The attached Plan of Correction describes how Regional One Health Extended Care Hospital will correct the cited deficiencies and the time frame for completion of the work; specifically the fire stop systems which will be used to repair each penetration.

We believe that the enclosed provides the requested information, but ask that you contact me at mkelly2@regionalonehealth.org or (901) 515-3030 if you have any questions, or if anything further is needed. Thank you in advance for your time and attention to this matter.

Sincerely,

Mark Kelly
CEO/Administrator

PRINTED: 02/23/2017
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531166-LT	A. BUILDING: 3F - REGION 1 HEALTH SUB ACUTE CARE B. WING _____	01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIONAL ONE HEALTH EXTENDED CARE HOSPITA	890 MADISON AVENUE, 4TH FLOOR MEMPHIS, TN 38103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	1200-08-01-.08 (1) Building Standards (1) A hospital shall construct, arrange, and maintain the condition of the physical plant and the overall hospital environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: National Fire Protection Association (NFPA) 101, 8.2.2.2 (2012 Ed.) Fire compartments shall be formed by fire barriers complying with 8.3. NFPA 101, 8.3.1.3 (2012 Ed.) Walls used as fire barriers shall comply with Chapter 7 of NFPA 221, Standard for High Challenge Fire Walls, Fire Walls, and Fire Barrier Walls. NFPA 221, 7.1 (2012 Ed.) Fire barrier walls shall meet the requirements of this chapter and Chapter 4 except as modified by this chapter. NFPA 221, 4.9.2 (2012 Ed.) Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. [5000:8.8.2] NFPA 221, 4.9.3 (2012 Ed.) Where the penetrating item uses a sleeve to	H 871	For all findings documented in this report, the Regional One Health Director, Engineering Services, is responsible for the corrective action and for overall/ongoing compliance. The Director is 3M Certified in Fire Protection and completed the 3M *Through Penetrations Program*. The Director and team will be utilizing Hilti systems and products. The experienced team from American Program Management, LLC. will continue to monitor projects. This firm specializes in health care facility design. Any contractors with a need to work above the ceiling will be required to contact Facility Engineering and complete an above ceiling permit prior to starting any work that affects fire barriers. A follow-up inspection will be conducted when work is completed to ensure 100% compliance with this requirement. The Administrator of Regional One Health Extended Care Hospital shall monitor the progress of Regional One Health's team to ensure completion. Ongoing review of environment services provided by Regional One Health Extended Care Optional, shall be monitored to ensure timely handling by the Regional One Health Extended Care Hospital quality program.	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531186-LT	A. BUILDING: 3F - REGION 1 HEALTH SUB ACUTE CARE B. WING _____	01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIONAL ONE HEALTH EXTENDED CARE HOSPITA	890 MADISON AVENUE, 4TH FLOOR MEMPHIS, TN 38103

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H 871	Continued From page 1 penetrate the wall or floor, the sleeve shall be securely set in the wall or floor, and the space between the item and the sleeve shall be filled with a material that complies with 4.9.2 and 4.9.2.1. [5000:8.8.3] Based on observations, the facility failed to maintain the physical plant. The findings included: 1. Observation on 1/11/17 at 12:07 PM, revealed the following penetrations in nursing pod C-3 above the 1 hour fire doors by patient room #22 in the drywall: a. 3 unapproved drywall patches. b. 1 easy sleeve not sealed at the wall. c. drywall tape seams and ends were exposed. d. the corner seam of the wall was not completely sealed. e. a 1 inch metal sleeve was not sealed per an approved method. f. a 1 3/4 inch metal sleeve was not sealed per an approved method. g. 2 - 4 inch white insulated lines were not sealed per an approved method. 2. Observation on 1/11/17 at 12:16 PM, revealed the following penetrations above the 1 hour fire doors by the dictation room in the drywall: a. drywall tape seams and ends were exposed. b. a 1 1/4 inch metal conduit sleeve was filled over 60% of the opening with cables.	H 871	1a. This issue will be repaired by reconstructing the wall as per UL465 wall construction detail. 1b. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 1c. This issue will be repaired by reconstructing the wall as per UL465 wall construction detail. 1d. This issue will be repaired by reconstructing the wall as per UL465 wall construction detail. 1e. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 1f. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 1g. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 2a. This issue will be repaired by reconstructing the wall as per UL465 wall construction detail. 2b. This issues will be repaired using Hilti approved fire stopping materials as per system number W-L-3393.	2/25/2017 2/25/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531186-LT	A. BUILDING: 3F - REGION 1 HEALTH SUB ACUTE CARE B. WING _____	01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIONAL ONE HEALTH EXTENDED CARE HOSPITA	890 MADISON AVENUE, 4TH FLOOR MEMPHIS, TN 38103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	Continued From page 2 c. an unapproved drywall patch above the sprinkler line. d. 11 - 1 inch metal conduits were not sealed per an approved method. 3. Observation on 1/11/17 at 12:21 PM, revealed the following penetrations above the 1 hour fire doors between the procedure room and the CEO's office in the drywall: a. 3 - 1 1/2 copper lines were not sealed per an approved method. b. a 1 inch metal conduit below the copper lines was not sealed per an approved method. c. an unapproved drywall patch. d. a 1/4 inch metallic flexible conduit had mixed fire stop. e. a 4 inch separation in the drywall above the metallic flexible conduit was not sealed. f. 2 - 1 inch metal conduits had mixed fire stop. g. a 1 3/4 inch steel black pipe had mixed fire stop. h. 4 - 1 inch metal conduit sleeves had mixed fire stop. i. 3 - 1 inch metal conduits were not sealed per an approved method. 4. Observation on 1/11/17 at 12:32 PM, revealed the following penetrations above the 1 hour fire doors by patient room #10 in the drywall:	H 871	2c.This issue will be repaired by reconstructing the wall as per UL465 wall construction detail. 2d. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 3a. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 3b. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 3c. This issue will be repaired by reconstructing the wall as per UL465 wall construction detail. 3d. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 3e. This issue will be repaired by reconstructing the wall as per UL465 wall construction detail. 3f. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 3g. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 3h. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 3i. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054.	2/25/2017 2/25/2017

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531186-LT	A. BUILDING: 3F - REGION 1 HEALTH SUB ACUTE CARE B. WING _____	01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGIONAL ONE HEALTH EXTENDED CARE HOSPITA	890 MADISON AVENUE, 4TH FLOOR MEMPHIS, TN 38103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	Continued From page 3 a. drywall tape seams and ends were exposed. b. the patient room wall had a 1 inch metal conduit with mixed fire stop. c. an unapproved drywall patch. d. a 2 1/2 inch black steel pipe was not sealed per an approved method. e. the 1 inch opening at the corner of the insulated duct work was not sealed. f. a 1 inch metal sleeve was not sealed at the wall. g. the 3 inch sprinkler line had mixed fire stop. 5. Observation on 1/11/17 at 12:40 PM, revealed the stairwell had the following penetrations in the 2 hour concrete block wall: a. a 1 inch metal conduit was not sealed inside the opening or at the wall. b. 2 - 1 inch metal conduits were sealed with gypsum mud. c. the 3 inch sprinkler line had mixed fire stop. 6. Observation on 1/11/17 at 12:45 PM, revealed the following penetrations above the 1 hour fire doors to the outpatient center in the drywall: a. drywall tape seams and ends were exposed. b. an unapproved drywall patch. c. a 5 inch black steel pipe was not sealed per an approved method.	H 871	4a. This issue will be repaired by reconstructing the wall as per UL465 wall construction detail. 4b. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 4c. This issue will be repaired by reconstructing the wall as per UL465 wall construction detail. 4d. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 4e. This issue will be repaired by reconstructing the wall as per UL465 wall construction detail. 4f. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 4g. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 5a. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 5b. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 5c. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 6a. This issue will be repaired by reconstructing the wall as per UL465 wall construction detail. 6b. This issue will be repaired by reconstructing the wall as per UL465 wall construction detail.	2/25/2017 2/25/2017 2/25/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531186-LT	A. BUILDING: 3F - REGION 1 HEALTH SUB ACUTE CARE B. WING _____	01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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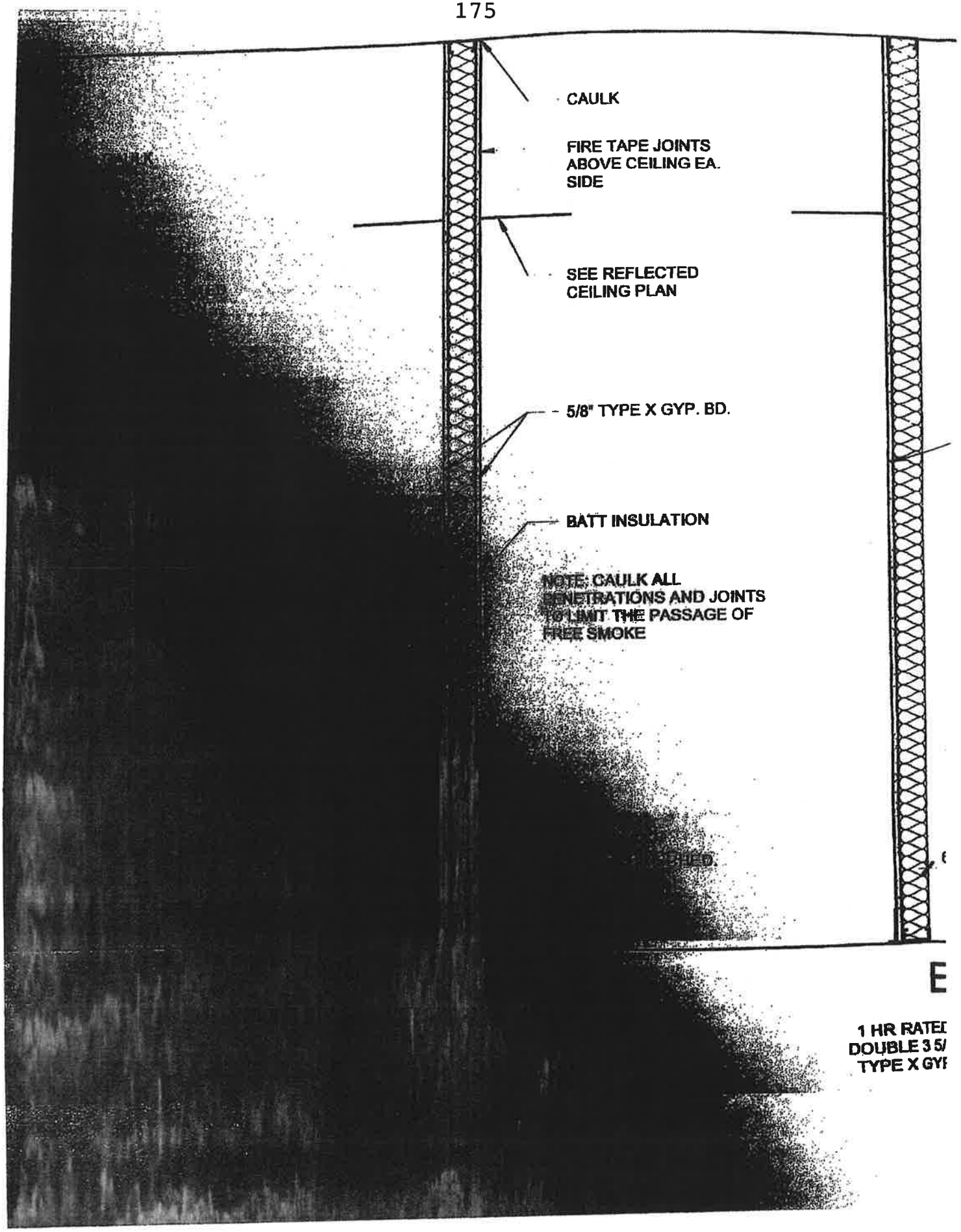
H 871	Continued From page 4 7. Observation on 1/11/17 at 12:50 PM, revealed the following penetrations above the 45 minute fire doors to the storage area: a. drywall tape seams and ends were exposed. b. 2 - 1 inch metal conduits were not sealed per an approved method. c. the 2 inch black steel sprinkler line had mixed fire stop. d. a 1 inch metal sleeve was not sealed at the wall. National Fire Protection Association (NFPA) 101, 8.2.2.2 (2012 Ed.) Fire compartments shall be formed by fire barriers complying with 8.3.1.3 (2012 Ed.) NFPA 221, 7.1 (2012 Ed.) NFPA 221, 4.9.2 (2012 Ed.) NFPA 221, 4.9.3 (2012 Ed.) The project manager was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit interview on 1/11/17.	H 871	6c. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 7a. This issue will be repaired by reconstructing the wall as per UL465 wall construction detail. 7b. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 7c. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054. 7d. This issue will be repaired using Hilti approved fire stopping materials as per system number W-L-1054.	2/25/2017 2/25/2017

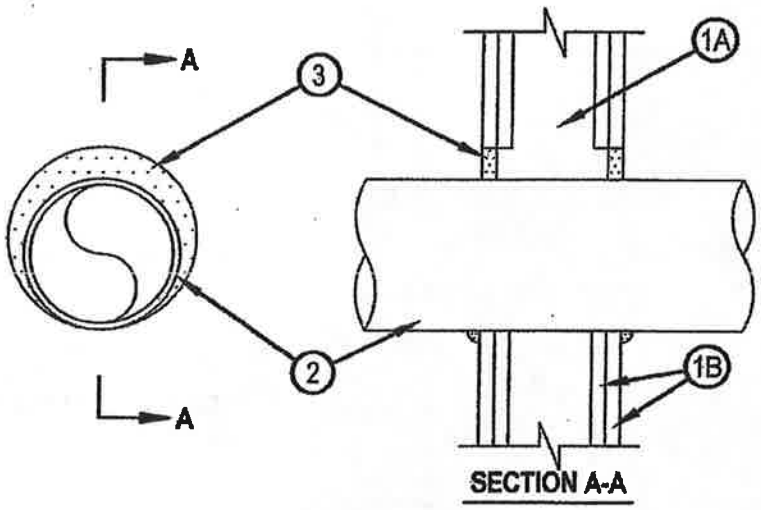
ATTACHMENT "A"


CAULK
FIRE TAPE JOINTS ABOVE CEILING EA. SIDE
SEE REFLECTED CEILING PLAN
5/8" TYPE X GYP. BD.
BATT INSULATION
NOTE: CAULK ALL PENETRATIONS AND JOINTS TO LIMIT THE PASSAGE OF FREE SMOKE
1 HR RATE
DOUBLE 3 5/
TYPE X GY

Classified by Underwriters Laboratories, Inc. to UL 1479 and CAN/ULC-S115

System No. W-L-1054

ANSI/UL1479 (ASTM E814)	CAN/ULC S115
F Ratings — 1 and 2 Hr (See Items 1 and 3)	F Ratings — 1 and 2 Hr (See Items 1 and 3)
T Rating — 0 Hr	FT Rating — 0 Hr
L Rating at Ambient — Less Than 1 CFM/sq ft	FH Ratings — 1 and 2 Hr (See Items 1 and 3)
L Rating at 400 F — Less Than 1 CFM/sq ft	FTH Rating — 0 Hr
	L Rating at Ambient — Less Than 1 CFM/sq ft
	L Rating at 400 F — Less Than 1 CFM/sq ft



SECTION A-A

1. Wall Assembly — The 1 or 2 hr fire-rated gypsum wallboard/stud wall assembly shall be constructed of the materials and in the manner specified in the individual U300 or U400 Series Wall and Partition Designs in the UL Fire Resistance Directory and shall include the following construction features:

   A. Studs — Wall framing may consist of either wood studs or steel channel studs. Wood studs to consist of nom 2 by 4 in. (51 by 102 mm) lumber spaced 16 in. (406 mm) OC. Steel studs to be min 2-1/2 in. (64 mm) wide and spaced max 24 in. (610 mm) OC. When steel studs are used and the diam of opening exceeds the width of stud cavity, the opening shall be framed on all sides using lengths of steel stud installed between the vertical studs and screw-attached to the steel studs at each end. The framed opening in the wall shall be 4 to 6 in. (102 to 152 mm) wider and 4 to 6 in. (102 to 152 mm) higher than the diam of the penetrating item such that, when the penetrating item is installed in the opening, a 2 to 3 in. (51 to 76 mm) clearance is present between the penetrating item and the framing on all four sides.

   B. Gypsum Board* — 5/8 in. (16 mm) thick, 4 ft (122 cm) wide with square or tapered edges. The gypsum board type, thickness, number of layers, fastener type and sheet orientation shall be as specified in the individual U300 or U400 Series Design in the UL Fire Resistance Directory. Max diam of opening is 32-1/4 in. (819 mm) for steel stud walls. Max diam of opening is 14-1/2 in. (368 mm) for wood stud walls.

The F and FH Ratings of the firestop system are equal to the fire rating of the wall assembly.

System No. W-L-1054

WL 1054

2. Through-Penetrants — One metallic pipe, conduit or tubing to be installed either concentrically or eccentrically within the firestop system. The annular space shall be min 0 in. to max 2-1/4 in. (57 mm). Pipe may be installed with continuous point contact. Pipe, conduit or tubing to be rigidly supported on both sides of wall assembly. The following types and sizes of metallic pipes, conduits or tubing may be used:
   A. Steel Pipe — Nom 30 in. (762 mm) diam (or smaller) Schedule 10 (or heavier) steel pipe.
   B. Iron Pipe — Nom 30 in. (762 mm) diam (or smaller) cast or ductile iron pipe.
   C. Conduit — Nom 4 in. (102 mm) diam (or smaller) steel electrical metallic tubing or 6 in. (152 mm) . diam steel conduit.
   D. Copper Tubing — Nom 6 in. (152 mm) diam (or smaller) Type L (or heavier) copper tubing.
   E. Copper Pipe — Nom 6 in. (152 mm) diam (or smaller) regular (or heavier) copper pipe.
3. Fill, Void or Cavity Material* — Sealant — Min 5/8 in. (16 mm) thickness of fill material applied within the annulus, flush with both surfaces of wall. At the point or continuous contact locations between pipe and wall, a min 1/2 in. (13 mm) diam bead of fill material shall be applied at the pipe wall interface on both surfaces of wall.
   HILTI CONSTRUCTION CHEMICALS, DIV OF HILTI INC — FS-One Sealant or FS-ONE MAX Intumescent Sealant

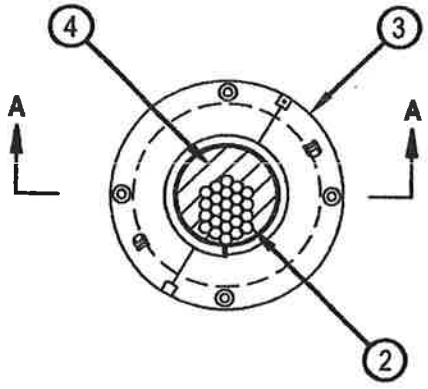
* Indicates such products shall bear the UL or cUL Certification Mark for jurisdictions employing the UL or cUL Certification (such as Canada), respectively.

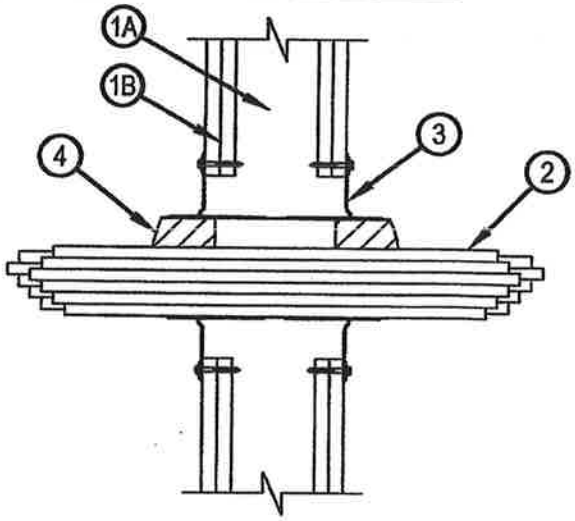
Classified by
Underwriters Laboratories, Inc.
to UL 1479 and CAN/ULC-S115

System No. W-L-3393

WL 3393

ANSI/UL1479 (ASTM E814)	CAN/ULC S115
F Ratings - 1 and 2 Hr (See Item 1)	F Ratings - 1 and 2 Hr (See Item 1)
T Ratings - 0, 3/4 and 1 Hr (See Items 2 and 3)	FT Ratings - 0, 3/4 and 1 Hr (See Items 2 and 3)
L Rating At Ambient - See Item 4	FH Ratings - 1 and 2 Hr (See Item 1)
L Rating At 400F - See Item 4	FTH Ratings - 0, 3/4 and 1 Hr (See Items 2 and 3)
	L Rating At Ambient - See Item 4
	L Rating At 400F - See Item 4





SECTION A-A

1. Wall Assembly — The 1 or 2 hr fire rated gypsum board/stud wall assembly shall be constructed of the materials and in the manner described within the individual U300, U400, V400 or W400 Series Wall and Partition Designs in the UL Fire Resistance Directory and shall incorporate the following construction features:
   A. Studs — Wall framing shall consist of either wood studs or steel channel studs. Wood studs to consist of nom 2 by 4 in. (51 by 102 mm) lumber spaced max 16 in. (406 mm) OC. Steel studs to be min 3-1/2 in. (89 mm) wide and spaced max 24 in. (610 mm) OC.
   B. Gypsum Board* — Nom 5/8 in. (16 mm) thick gypsum board as specified in the individual Wall and Partition Design. Opening in gypsum board to be max 8 in. (203 mm) diam for 4" device and max 6 in. (152 mm) diam for 2" device.

   The hourly F and FH Ratings of the firestop system are dependent upon the hourly rating of the wall in which it is installed.

WL 3393

2. Cables — Within the loading area for each firestop device, the aggregate cross-sectional area of cables to be min 0 to max 60 percent fill. Cables to be tightly bundled within the device and rigidly supported on both sides of wall assembly. Any combination of the following types of cables may be used:
   A. Max 100 pair No. 24 AWG (or smaller) copper conductor telecommunication cable with polyvinyl chloride (PVC) jacketing and insulation.
   B. Max 7/C No. 12 AWG copper conductor control cable with PVC or XLPE jacket and insulation.
   C. Max 4/0 AWG Type RHH ground cable.
   D. Max 4 pr No. 22 AWG Cat 5 or Cat 6 computer cables.
   E. Max RG 6/U coaxial cable with fluorinated ethylene insulation and jacketing.
   F. Fiber optic cable with polyvinyl chloride (PVC) or polyethylene (PE) jacket and insulation having a max diam of 1/2 in. (13 mm).
   G. Max 3/C No 12 AWG MC Cable.

   For opening with cables, when the hourly rating of the wall assembly is 1 hr, the T, FT and FTH Ratings are 0 hr. For opening with cables, when the hourly rating of the wall assembly is 2 hr, the T, FT and FTH Ratings are 1 hr except that when Item 2C is used, the T, FT and FTH Ratings are 3/4 hr.
3. Firestop Device* — Firestop device consists of a corrugated steel tube with a flange at each end that is spun clockwise onto device threads, butting tightly to both sides of wall. Each flange is secured to face of wall with min four No. 10 by 1-1/2 in. (38 mm) steel laminating screws through prepunched holes in flange. Device is designed to allow installation before or after the cable penetrants are in place. Device slid into wall such that ends project an equal distance from the approximate centerline of the wall assembly. The annular space between the device and the periphery of the opening shall be min 0 in. (point contact) to max 2 in. (51 mm). For blank openings (no cables) in 2 hr rated walls, the T, FT and FTH Ratings for the firestop system are 1 hr. For blank openings (no cables) in 1 hr rated walls, the T, FT and FTH Ratings are 0 hr.
   HILTI CONSTRUCTION CHEMICALS, DIV OF HILTI INC — CFS-SL RK 2" and 4" Firestop Sleeve
4. Fill, Void or Cavity Material* - Plug — Nom 2 or 4 in. (51 or 102 mm) plug sized for the firestop device (Item 3) friction fit within the sleeve flush with the end of the sleeve on both sides of the wall assembly. Plug cut to fit around the cable bundle and installed tightly within the sleeve.
   HILTI CONSTRUCTION CHEMICALS, DIV OF HILTI INC — CFS-PL Firestop Plug

The following L Ratings are covered. Cable bundle shall be centered within the device.

	CFM (per device)		CFM/Sq Ft Opening	
	Ambient	400°F	Ambient	400°F
Blank Opening (no cables)	1.3	1.1	3.8	3.0
Max 33% aggregate cable fill	2.8	1.2	8.1	3.3

{{ a_image.include (src=global.dir.assets + '/images/logo_2016_sRGB.svg', srcXs=global.dir.assets + '/images/logo_2016_sRGB.svg') }}

FIRESTOP SEALANT FS-ONE MAX

Take coverage and performance to the max.

Even the best product on the market can be improved. That's why we've updated the premier intumescent Firestop Sealant FS-ONE to Hilti Firestop Sealant FS-ONE MAX. With an extended shelf life, improved handling and an ethylene glycol-free composition, FS-ONE MAX is the next generation of intumescent firestop sealant.

FS-ONE MAX directly replaces Hilti Firestop Selant FS-ONE. In addition, all of our UL systems have been updated to reflect the new, improved FS-ONE MAX. That means you'll now find more than 600 UL systems to help protect combustible and non-combustible penetrations for up to 4 hours of fire rating.

Applications

- Seal most common through penetrations in a variety of base materials
- Use on concrete, masonry and drywall
- Use with mixed and multiple penetrations
- Seal metal pipe penetrations: copper, steel and EMT
- Seal insulated metal pipe penetrations: steel and copper

Advantages

- Versatile: an intumescent firestop sealant for a wide variety of penetrations
- Effective: smoke, gas and water resistant
- Workable: water-based material is easy to dispense and apply
- Paintable: trowel to a smooth finish
- Storable: long shelf life
- Cleaner: ethylene glycol-free

- Flexible: W-rated systems available
- American: satisfies Buy American standards

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High-performance intumescent firestop sealant

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Hilti USA
Service Hotline: **(800) 879-8000**

CERTIFICATE OF COMPLIANCE

Certificate Number 20150108-R13240
Report Reference R13240
Issue Date 2015-January-08

Issued to: Hilti Construction Chemicals, Div of Hilti Inc.
5400 S 122nd East Ave
Tulsa, OK 74146

This is to certify that representative samples of Fill, Void or Cavity Materials
Fill, Void or Cavity Materials Certified for Canada
FS-ONE MAX Intumescent Sealant for use in Through-Penetration Firestop and Joint Systems in the UL Fire Resistance Directory and in the Products Certified for Canada Directory.

Have been investigated by UL in accordance with the Standard(s) indicated on this Certificate.

Standard(s) for Safety: [redacted] Fire Tests of Through-Penetration Firestops," – Edition 4
ANSI/UL 2079, "Tests for Fire Resistance of Building Joint Systems," – Edition 4 – Revision Date 2014/12/17
CAN/ULC-S115, "Standard Method of Fire Tests of Firestop Systems," – Edition 4 – Issue Date 2011/06/01

Additional Information: See the UL Online Certifications Directory at www.ul.com/database for additional information

Only those products bearing the UL Classification Mark should be considered as being covered by UL's Classification and Follow-Up Service.

The UL Classification Mark includes: UL in a circle; with the word "CLASSIFIED" (as shown); a control number (may be alphanumeric) assigned by UL; a statement to indicate the extent of UL's evaluation of the product; and the product category name (product identity) as indicated in the appropriate UL Directory.

Look for the UL Classification Mark on the product.

William R. Carney

William R. Carney, Director, North American Certification Programs
UL LLC

Retrofit Sleeve Kit CFS-SL RK

Product description

- Retrofit cable management device for easily and safely firestopping existing cable applications
- Offered in 2" and 4" diameter versions
- Standard kit includes (1) retrofit sleeve (2) retrofit flanges with smoke seal (2) Firestop Plugs CFS-PL

Product features

- Fast and easy installation for existing cables with ability to re-penetrate
- Integrated smoke seal eliminates the need to add sealant behind the flange
- Oversized flanges for irregular and large openings
- Pre-cured, pre-formed firestop material does not expire, eliminating shelf-life concerns
- Protects most typical firestop cable applications
- 4" diameter device is compatible with the Hilti Gangplate (CFS-SL GP)
- Buy American compliant
- Meets LEED™ requirements for indoor environmental quality credit 4.1 Low Emitting Materials, Sealants and Adhesives
- Low VOC content and no CFCs or HCFCs

Areas of application

- Single and bundled cables in gypsum and CMU walls

Examples

- Safely firestopping existing cable applications in fire rated walls, especially where future re-penetration is needed

Technical Data	CFS-SL RK
2" Device	Sleeve: OD 2.5 in / ID 2.3 in Flange: OD 8 in
4" Device	Sleeve: OD 4.5 in / ID 4.3 in Flange: OD 10 in
Overall sleeve length	10.5 in
Expansion ratio (unrestricted)	Approx. 1:3
Temperature resistance	5° F to 140° F (-15° C to 60° C)
Intumescent activation	Approx. 392° F (200° C)
Surface burning characteristics (ASTM E 84-10b)	Flame Spread: 10 Smoke Development: 15
Tested in accordance with	ASTM E 814 [illegible] ASTM E 84 (CFS-PL only)

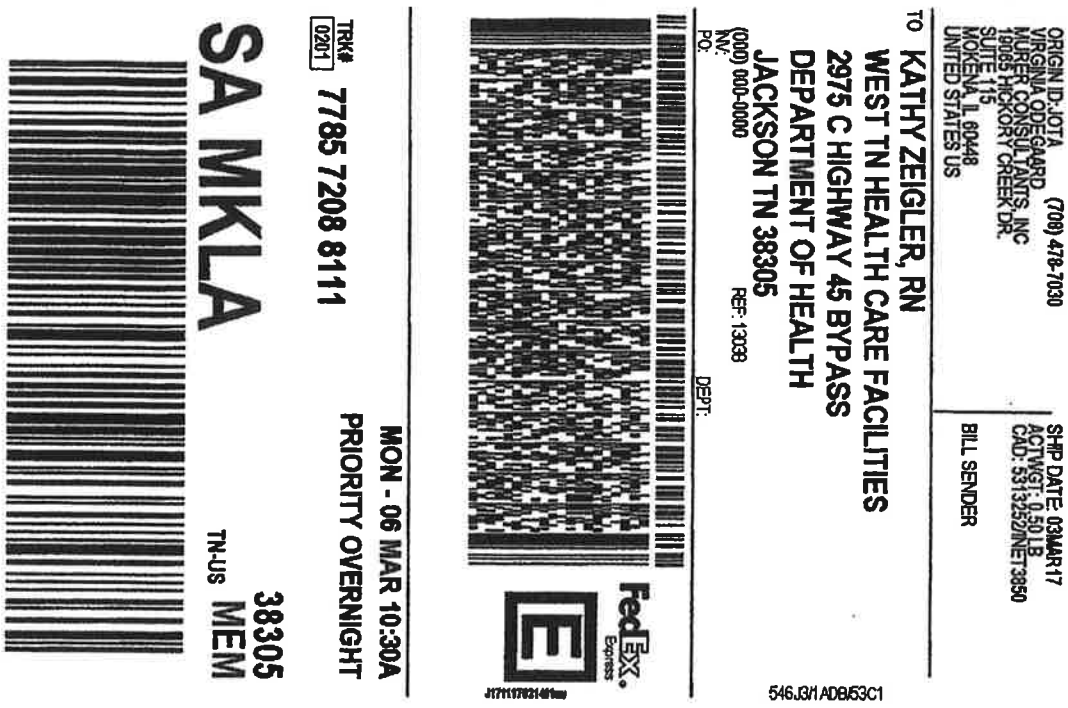
FIRESTOP DEVICE
FOR USE IN THROUGH-PENETRATION FIRESTOP SYSTEMS
SEE UL FIRE RESISTANCE DIRECTORY SW76

Installation instructions for Firestop Retrofit Sleeve Kit

See Hilti Literature or third-party listings for complete application and installation details

Hilti Firestop
Saving lives through innovation and education

Hilti. Outperform. Outlast.



After printing this label:
1. Use the 'Print' button on this page to print your label to your laser or inkjet printer.
2. Fold the printed page along the horizontal line.
3. Place label in shipping pouch and affix it to your shipment so that the barcode portion of the label can be read and scanned.

Warning: Use only the printed original label for shipping. Using a photocopy of this label for shipping purposes is fraudulent and could result in additional billing charges, along with the cancellation of your FedEx account number.
Use of this system constitutes your agreement to the service conditions in the current FedEx Service Guide, available on fedex.com.FedEx will not be responsible for any claim in excess of $100 per package, whether the result of loss, damage, delay, non-delivery,misdelivery,or misinformation, unless you declare a higher value, pay an additional charge, document your actual loss and file a timely claim.Limitations found in the current FedEx Service Guide apply. Your right to recover from FedEx for any loss, including intrinsic value of the package, loss of sales, income interest, profit, attorney's fees, costs, and other forms of damage whether direct, incidental,consequential, or special is limited to the greater of $100 or the authorized declared value. Recovery cannot exceed actual documented loss.Maximum for items of extraordinary value is $1,000, e.g. jewelry, precious metals, negotiable instruments and other items listed in our ServiceGuide. Written claims must be filed within strict time limits, see current FedEx Service Guide.

Maupin, Susan

From: TrackingUpdates@fedex.com
Sent: Monday, March 06, 2017 9:11 AM
To: Maupin, Susan
Subject: FedEx Shipment 778572088111 Delivered

Your package has been delivered

Tracking # 778572088111

Ship date:
Fri, 3/3/2017

Virginia Odegaard
MURER CONSULTANTS, INC
MOKENA, IL 60448
US

Delivered

Delivery date:
Mon, 3/6/2017 9:08 am

Kathy Zeigler, RN
West TN Health Care Facilities
2975 C Highway 45 Bypass
Department of Health
JACKSON, TN 38305
US

Shipment Facts

Our records indicate that the following package has been delivered.

Tracking number:	778572088111
Status:	Delivered: 03/06/2017 09:08 AM Signed for By: B.STRICKLAND
Reference:	13038
Signed for by:	B.STRICKLAND
Delivery location:	JACKSON, TN
Delivered to:	Receptionist/Front Desk
Service type:	FedEx Priority Overnight
Packaging type:	FedEx Envelope
Number of pieces:	1
Weight:	0.50 lb.
Special handling/Services:	Deliver Weekday
Standard transit:	3/6/2017 by 10:30 am

All weights are estimated.

To track the latest status of your shipment, click on the tracking number above.

Standard transit is the date and time the package is scheduled to be delivered by, based on the selected service, destination and ship date. Limitations and exceptions may apply. Please see the FedEx Service Guide for terms and conditions of service, including the FedEx Money-Back Guarantee, or contact your FedEx Customer Support representative.

Thank you for your business.

TN Department of Health

April 5, 2017

Mr. Mark Kelly, Administrator
Regional One Health Extended Care Hospital
890 Madison Avenue, 4th Floor
Memphis, TN 38103

RE: Fire Safety Licensure Survey

Dear Mr. Kelly:

The West of Health Care Facilities completed a fire safety licensure survey on **January 11, 2017**. Based on the revisit completed **March 31, 2017**, we are accepting your plan of correction and found your facility to be in substantial compliance with all participation requirements as of **February 25, 2017**.

If you have any questions, please contact at West Tennessee Regional Office at 731-984-9684.

Sincerely,

Kathy Zeigler

Kathy Zeigler, RN
Public Health Nurse Consultant 2

KZ/tw

The Commercial Appeal
Affidavit of Publication

STATE OF TENNESSEE
COUNTY OF SHELBY

Personally appeared before me, Glenn W. Edwards, a Notary Public, Helen Curl, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennessee, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached advertisement was published in the following editions of The Commercial Appeal, to-wit:

January 10, 2018

Helen Curl

Subscribed and sworn to before me this 10th day of January, 2018.

Glenn W. Edwards Notary Public

My commission expires January 20, 2020.

The Commercial Appeal
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CRANKSHAFT By Tom Batiuk & Chuck Ayers

FRANK & ERNEST By Bob Thaves

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Wanted to Buy

Financial

Business Opportunities

Legals

Legal Notices

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on February 1, 2018 at 10:00 a.m., local time, at the south door of the Weakley County Courthouse, 116 West Main Street, Dresden, TN 38225, pursuant to Deed of Trust executed by Kent Yoesel and Belinda Yoesel to John Brawn, as Trustee for First State Finance, Inc., dated November 21, 2016, of record in Book T635, Page 723, in the Register's Office for Weakley County, Tennessee ("Deed of Trust"), conducted by Padgett Law Group, having been appointed Substitute Trustee, all of record in the Weakley County Register's Office. Default in the performance of the covenants, terms, and conditions of said Deed of Trust has been made; and the entire indebtedness has been declared due and payable.

Party entitled to enforce the debt: Simmons Bank

Other interested parties: Tennessee Housing Development Agency

The hereinafter described real property located in Weakley County will be sold to the highest call bidder subject to all unpaid taxes, prior liens and encumbrances of record.

Legal Description: All that certain property situated in the County of WEAKLEY and State of TENNESSEE, being described as follows: DESCRIBED LAND, SITUATED IN THE 6TH CIVIL DISTRICT OF THE COUNTY OF WEAKLEY AND STATE OF TENNESSEE, AND MORE PARTICULARLY DESCRIBED AS FOLLOWS: BEGINNING AT AN IRON PIN IN THE EAST RIGHT-OF-WAY OF A 30 FEET RIGHT-OF-WAY OF HUNT STREET, SAID PIN BEING 5.7 FEET EAST OF THE EAST EDGE OF A 20-FOOT WIDE ASPHALT PAVEMENT OF SAID STREET, SAID PIN ALSO BEING THE SOUTHWEST CORNER OF A LOT BELONGING TO BULLINGTON AND BEING 310 FEET SOUTH OF THE CENTER OF MAPLE STREET; THENCE SOUTH 85 DEGREES 03 MINUTES 20 SECONDS EAST WITH THE SOUTH LINE OF BULLINGTON, FOR A DISTANCE OF 236.00 FEET TO AN IRON PIN, SAID PIN BEING IN THE WEST LINE OF A TRACT BELONGING TO WATLINGTON; THENCE SOUTH 30 DEGREES 50 MINUTES 00 SECONDS WEST, WITH THE WEST LINE OF WATLINGTON, FOR A DISTANCE OF 124.00 FEET TO AN IRON PIN IN A FENCE, SAID PIN BEING THE NORTHEAST CORNER OF A LOT BELONGING TO BREWER; THENCE NORTH 86 DEGREES 00 MINUTES 20 SECONDS WEST WITH BREWER'S NORTH LINE, FOR A DISTANCE OF 236.00 FEET TO AN IRON PIN AT BREWER'S NORTHWEST CORNER, SAID PIN ALSO BEING IN THE EAST RIGHT-OF-WAY OF HUNT STREET AND BEING 3.8 FEET EAST OF THE EAST EDGE OF THE ASPHALT PAVEMENT OF SAID STREET; THENCE NORTH 30 DEGREES 50 MINUTES 00 SECONDS EAST WITH THE EAST RIGHT-OF-WAY OF HUNT STREET, FOR A DISTANCE OF 124.00 FEET TO THE POINT OF BEGINNING, AND CONTAINING 25,719 SQUARE FEET OR 0.671 ACRES, ACCORDING TO A SURVEY DATED APRIL 24, 1931, BY ROBERT L. NICHOLS, TN RLS NO. 1009, P.O. BOX 1007, UNION CITY, TN, WITH ALL BEARINGS BASED UPON MAGNETIC NORTH. INCLUDED IN THE ABOVE DESCRIPTION, BUT EXPRESSLY EXCLUDED FROM THIS CONVEYANCE IS THE FOLLOWING DESCRIBED TRACT: BEGINNING AT AN IRON PIN AT BREWER'S PRESENT NORTHWEST CORNER, SAID PIN ALSO BEING IN THE EAST RIGHT OF WAY OF HUNT STREET AND BEING 3.8 FEET EAST OF THE EAST EDGE OF THE ASPHALT PAVEMENT OF SAID STREET; THENCE NORTH 03 DEGREES, 50 MINUTES, 00 SECONDS EAST WITH THE EAST RIGHT OF WAY OF HUNT STREET FOR A DISTANCE OF 10 FEET TO A POINT; THENCE IN AN EASTERLY DIRECTION, MAKING A NEW LINE AND PASSING THROUGH TWO (2) TREES, APPROXIMATELY 236 FEET TO A POINT IN THE WEST LINE OF WATLINGTON; THENCE SOUTH 00 DEGREES, 50 MINUTES, 00 SECONDS WEST, WITH THE WEST LINE OF WATLINGTON, 15 FEET TO AN IRON PIN, BREWER'S PRESENT NORTHEAST CORNER; THENCE WITH BREWER'S PRESENT NORTH LINE, NORTH 86 DEGREES, 00 MINUTES, 20 SECONDS WEST, 236.0 FEET TO THE POINT OF BEGINNING, CONTAINING A FRACTION OF AN ACRE.

Street Address: The street address of the property is believed to be 233 South Hunt Street, Sharon, TN 38255, but such address is not part of the legal description of the property. In the event of any discrepancy, the legal description herein shall control.

Map/Parcel Number: 110O A 01100 000

Current owner(s) of Property: Kent Yoesel

This sale is subject to all matters shown on any applicable recorded Plat or Plan; any unpaid taxes and assessments; any restrictive covenants, easements or setback lines that may be applicable; rights of redemption, equity, statutory or otherwise, not otherwise waived in the Deed of Trust, including rights of redemption of any governmental agency, state or federal; and any and all prior deeds of trust, liens, dues, assessments, encumbrances, defects, adverse claims and other matters that may take priority over the Deed of Trust upon which this foreclosure sale is conducted or are not extinguished by this Foreclosure Sale.

THE PROPERTY IS SOLD WITHOUT ANY REPRESENTATIONS OR WARRANTIES, EXPRESSED OR IMPLIED, RELATING TO TITLE, MARKETABILITY OF TITLE, POSSESSION, QUIET ENJOYMENT OR THE LIKE AND FITNESS FOR A GENERAL OR PARTICULAR USE OR PURPOSE. The title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.

The right is reserved to adjourn the sale to another time certain or to another day, time, and place certain, without further publication upon announcement on the day, time, and place of sale set forth above or any subsequent adjourned day, time, and place of sale.

If you purchase a property at the foreclosure sale, the entire purchase price is due and payable at the conclusion of the auction in the form of a certified check made payable to or endorsed to Padgett Law Group. No personal checks will be accepted. To this end, you must bring sufficient funds to outbid the lender and any other bidders. Insufficient funds will not be accepted. Amounts received in excess of the winning bid will be refunded to the successful purchaser at the time the foreclosure deed is delivered.

This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded by the Substitute Trustee at any time.

THIS IS AN ATTEMPT TO COLLECT A DEBT, AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

Padgett Law Group, Substitute Trustee
6267 Old Water Oak Road, Suite 203
Tallahassee, Florida 32312
PH: (850) 422-2520
FX: (850) 422-2567
PLG#17-010665

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on **February 20, 2018 at 11:00AM** local time, at the south door, Weakley County Courthouse, 116 West Main Street, Dresden, Tennessee pursuant to Deed of Trust executed by Thomas A Foley, Sr and Carrie S Foley, to Richmond Title Services, TN, Trustee, as trustee for Financial Freedom Senior Funding Corporation, a subsidiary of IndyMac Bank F.S.B. on October 25, 2005 at Book T 013, Page 950; conducted by Shapiro & Ingle, LLP, having been appointed Substitute or Successor Trustee, all of record in the Weakley County Register's Office. Default has occurred in the performance of the covenants, terms, and conditions of said Deed of Trust and the entire indebtedness has been declared due and payable.

Party Entitled to Enforce the Debt: CIT Bank, N.A., its successors and assigns.

The following real estate located in Weakley County, Tennessee, will be sold to the highest call bidder:

Described property located at Weakley County, Tennessee, to wit:

The land referred to herein is situated in the State of Tennessee, County of Weakley described as follows:

BEGINNING AT A POINT IN THE CENTER OF A COUNTRY ROAD, THE SWC OF THE LOT BEING CONVEYED AND ONE OF THE NWC'S OF BROWN (NOW HOWELL); THENCE N 88° E WITH THE NORTH LINE OF BROWN (NOW HOWELL) 160 FEET TO A STAKE; THENCE, MAKING A NEW LINE, N 1° 33' W 250 FEET TO A STAKE; THENCE IN A WESTERLY DIRECTION AND PARALLEL WITH ONE OF THE NORTH LINES OF HOWELL 140 FEET TO THE CENTER OF THE COUNTY ROAD; THENCE IN A SOUTHERLY DIRECTION WITH THE CENTER OF THE COUNTY ROAD 290 FEET TO THE POINT OF BEGINNING, AND CONTAINING 1 ACRES, MORE OR LESS.

THIS IS A PART OF THE PROPERTY CONVEYED TO HARRY L. BURNS AND WIFE, EDNA L. BURNS, BY DEED OF MASON KEMP AND WIFE HOPE KEMP, DATED JULY 30, 1971, OF RECORD IN DEED BOOK 157, PAGE 128, ROWCT.

SOURCE OF TITLE: BOOK 713, PAGE 210, (RECORDED 12/11/1979)

Street Address: 314 Burns Rd, Cottage Grove, Tennessee 38224

Parcel Number: 045 013 01

Current Owner(s) of Property: The Heirs of Thomas A. Foley, Sr.

The street address of the above described property is believed to be 314 Burns Rd, Cottage Grove, Tennessee 38224, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description herein shall control.

This sale is subject to, without limitation, all matters shown on any applicable recorded plat; any unpaid taxes; any restrictive covenants, easements, or setback lines that may be applicable; any statutory right of redemption of any governmental agency, state or federal; any prior liens or encumbrances including those created by a fixture filing or any applicable homeowners' association dues or assessments; all claims or other matters, whether of record or not, which may encumber the purchaser's title and any matter that an accurate survey of the premises might disclose.

The following parties may claim an interest in the above-referenced property to be affected by the foreclosure: any judgment creditor or lien holder with an interest subordinate to the said Deed of Trust or any party claiming by, through, or under any of the foregoing. Such parties known to the Substitute Trustee may include: Secretary of Housing and Urban Development. All parties claiming by, through or under Thomas Foley Sr.

Terms of Sale will be public auction, for cash, free and clear of rights of homestead, redemption and dower to the extent disclaimed or inapplicable, and the rights of Thomas A Foley, Sr and Carrie S Foley, and those claiming through him/her/it/them.

Any right of equity of redemption, statutory and otherwise, and homestead are waived in accord with the terms of said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.

Legal Notices

NOTIFICATION OF INTENT TO APPLY FOR
A Certificate of Need

[illegible]

The anticipated date of filing the application is on or before January 15, 2018.

[illegible]

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

[illegible]

Legal Notices

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Open Arms Care Corporation, a Georgia non-profit corporation qualified to do business in Tennessee, intends to file an application for a Certificate of Need for the replacement and relocation of an eight-person Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), managed by Integra Resources, LLC, a Tennessee limited liability company. The facility is currently located at 5380 [illegible]town Road, Memphis, Shelby County, Tennessee [illegible], and will be relocated to a lot consisting of two parcels, for a total of approximately [illegible] acres, a portion of which currently has an address of 8948 Macon Road, Cordova, Tennessee and a portion of which currently does not have separate street address, such lot is also described as two separate parcels, being Parcel 09[illegible] and Parcel 09[illegible] in the records of the Shelby County Tax Assessor. The estimated project cost is $5,130,000.00.

The anticipated filing date of the application is on or before January 15, 2018. The contact person for this project is Michael [illegible], who may be reached at Bradley Arant Boult Cummings LLP, 1600 Division Street, Suite 700, Nashville, Tennessee 37203. Mr. [illegible]'s telephone number is (615) 252-[illegible] and his email address is [illegible]@bradley.com.

Upon written request by interested parties, a local fact-finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

[illegible]

Building Supplies

Machinists

Supplemental #1 (Copy)

Regional MED Extended Care Hospital, LLC, dba Regional One Health Extended Care Hospital

CN1801-003

1. **Section A, Executive Summary, Overview, A.1.**

Based upon the information provided by the applicant, it appears the 25% Rule will go into effect October 1, 2018, just a few months after completion of this project. Utilizing the tables below please identify the current admission pattern to the LTACH and project how that may change after completion of the proposed project.

Historical Inpatient Admissions by Admission Source-2014-2016

Admission Source	2014 Admissions	% Total	2015 Admissions	% Total	2016 Admissions	% Total
Reg One	34	54%	88	49%	102	53%
Other Hosp	29	46%	93	51%	94	47%
TOTAL	63	100%	181	100%	196	100%

Projected Inpatient Admissions by Admission Source-2019-2020

Admission Source	Year 1 Admissions	% Total	Year 2 Admissions	% Total
Reg One	9243	55%	9243	55%
Other Hosp	7562	45%	7562	45%
TOTAL	16805	100%	16805	100%

Response: Historically, between 50% and 55% of our LTACH patients originate from Regional One, our host hospital. All other patients originate from other hospitals, with no other hospital providing anywhere close to 25% of our patients. In fact, only one year has an "other" hospital provided more than 10% of our patients, and that was a local hospital in Memphis. We estimated 55% of our future (Year 1 and Year 2) patients would originate from our host hospital.

Second, the projected chart above correctly identifies the projected admissions as "Year 1" and "Year 2." However, please note that the chart name is incorrectly identified as "2019-2020." We do not know exactly when the new beds will open, but are comfortable estimated for Year 1 and Year 2, as opposed to actual calendar or fiscal years.

Please note, the following information should be understood in conjunction with the 25 Percent Threshold Policy ("Policy"). The Policy is a per discharge payment adjustment to the LTACH PPS that is applied to payments for Medicare patient discharges when the number of patients originating from any single referring hospital (based upon CCN) is in excess of 25 percent of the total Medicare discharges.[1] If the LTACH exceeds the threshold during the current cost reporting period, payment of the discharge that puts the LTACH over the 25 percent threshold and all discharges subsequent to that discharge are subject to an adjusted reimbursement. Discharges **not** in excess of the 25 percent threshold are unaffected by the Policy. Additionally, if the patient was transferred from an acute care hospital that already qualifies for outlier payments or it is a Medicare Advantage Plan patient, the admission does not count towards the hospital's allowable percentage.

[1] Medicare Discharges from *Hospital X* (Minus outlier patients & Medicare Advantage patients) / Total Medicare Discharges (Minus Medicare Advantage Patients)

It is also important to note that the Policy is currently **not** in effect. The Bipartisan Budget Act of 2013 delayed application of the Policy, implementation was further suspended under the 21st Century Cures Act. In addition, the Fiscal Year 2018 Final Rule postponed the implementation yet again, until October 1, 2018.[2] The reason for the current postponement, as explained in the Federal Register issued by CMS, is in order that they may be better able to examine the data under the application of the site neutral payment rate. As stated by CMS, this examination is necessary in order to determine whether the Policy remains necessary and appropriate, in light of the additional measures currently in place.

At this time, it is underdetermined whether the 25 Percent Threshold Policy will in fact remain necessary and appropriate on October 1, 2018.[3]

Assuming that the floor plan for Turner Floors #3 and #4 are the same, please explain why it will be economically feasible to staff all 24 beds on Floor #3 but only to continue to staff 21 of 24 beds on Floor #4.

Response: The Applicant currently staffs all 24 beds on the 4th floor. As explained in the application, at first, we were unable to staff 3 of those beds due to the positioning of the beds on the floor as related to the nurses' station(s). In effect, our costs to staff those 3 beds exceeded the revenue from those beds. Much of the historical information (e.g., occupancy rate, patient revenue) given in the application reflects data for just 21 beds, and the explanation is given why those 3 beds were not staffed. However, due to the closing of the facility at Methodist, the demand for LTACH beds at our facility have exceeded our ability to provide those beds, and we made plans to start staffing all 24 beds on that floor some time ago due to the fact we believe we can fill those beds. The increase in total beds at our LTACH provides us with the additional revenue necessary to absorb the cost of staffing those unique beds. We attempted to explain this on page 38 of the application, as follows:

> "It is important to note that the Applicant had been staffing only 21 beds since licensure. This restriction is a reflection of the layout of our beds, and staffing the additional three (3) beds on the fourth floor originally resulted in financial loss. Therefore, the fact that we averaged 20.21 patients in a 21 bed facility is indicative of how our existing staffed beds are utilized to capacity. We now staff all 24 beds due to increased demand."

It is noted that the decision on where to relocate the rehab beds has not been made. What are the options under consideration? Are there empty nursing units on the Regional One Health campus to accommodate these beds?

Response: There remains a need for some rehab beds at our facility. Our only option is to relocate the beds from the 3rd floor of Turner Tower, but we have not concluded our research as to where the beds might be relocated, as stated in the application. We understand that the movement of rehab beds might well trigger another Certificate of Need application. Other than that, we continue to research the various locations where the rehab beds might be relocated, but prefer not to speculate until our research is completed.

---

[2] There was a three month gap period between 7/1/2016 and 10/1/2016 in which the Policy applied, but since it utilized full year discharges in comparison to the three month threshold period, CMS has indicated there was no practical effect of the Policy during the gap period.

[3] 82 CFR 37990 at 38318-38320

How will the 24 beds on the third floor be separated from the general patient population of Regional One Health?

Response: These beds will be separated as are the existing LTACH beds, and the separation currently and will continue to comply with Licensure standards. As reported on page 2 of the application:

> "The Applicant is approved to add six (6) LTACH beds on the 2nd floor, plus this project is to add twenty-four (24) beds on the 3rd floor. The Applicant has discussed these projects with Licensure, and both projects meet licensure standards."

In addition, the 4th floor is a discrete unit attached to but separated from the main hospital by corridors and locked doors, and both the 24 beds on the 3rd floor and the 6 beds on the 2nd floor will be likewise separated from other services on their respective floors.

2. **Section A, Project Details, Item 6. Legal Interest in the Site**

   The Option to Lease included in the application indicates that if a CON is not filed within 90 days of the execution of the Option to Lease, the Option to Lease will terminate. The Option to Lease was executed on August 11, 2017. The application was filed on January 11, 2017, a date which is greater than 90 days from the executed Option to Lease.

   Please files a valid and fully executed Option to Lease and be sure that the period of validity is at least to some date after the expected approval date by HSDA.

Response: Unfortunately, the snow on January 12th, coupled with the State Holiday on January 15th resulted in our application being submitted prior to all documents being executed. Please see new Supplemental Option to Lease.

3. **Section A, Project Details, Item 6B-(2) Floor Plan**

   The floor plans submitted are noted; however, they are for the 2nd and 4th floors. Please provide a floor plan for the 3rd floor, which includes labeling of patient care rooms.

Response: Please see Supplemental 3rd floor footprint.

4. **Section A, Project Details, Item 10, Bed Complement Data Chart**

   For the existing 24 bed unit the chart indicates that all 24 of the licensed beds are staffed while in other parts of the application the indication is that 21 of the 24 beds are staffed.

   Please address this discrepancy.

Response: The Applicant currently staffs all 24 beds on the 4th floor. As explained in the application, when we first opened our LTACH, we were unable to staff 3 of those beds due to the positioning of the beds on the floor as related to the nurses' station(s). In effect, our costs to staff those 3 beds exceeded the revenue from those beds. Much of the historical information (e.g., occupancy rate, patient revenue) given in the application reflects data for just 21 beds, and the explanation is given why those 3 beds were not staffed. However, due to the closing of the facility at Methodist, the demand for LTACH beds at our facility have exceeded our ability to provide those beds, and we made plans to start staffing all 24 beds on that floor some time ago due to the fact we believed we could fill those beds. The increase in total beds at our LTACH provides us with the additional revenue necessary to absorb the cost of staffing those unique beds. We attempted to explain this on page 38 of the application, as follows:

> "It is important to note that the Applicant had been staffing only 21 beds since licensure. This restriction is a reflection of the layout of our beds, and staffing the additional three (3) beds on the fourth floor originally resulted in financial loss. Therefore, the fact that we averaged 20.21 patients in a 21 bed facility is indicative of how our existing staffed beds are utilized to capacity. We now staff all 24 beds due to increased demand."

5. **Section B, Need, Item A Section C, Item 1.a. (Long Term Care Hospital Beds-A. Need 1.)**

Please complete the following table:

County	Existing LTACH Beds	*Needed LTACH Beds	+ Surplus/ -Need
Shelby	99	50	(49)

*Calculate Need as follows: 0.5 X (2020 County Population/10,000) = Needed LTACH Beds

Response: The chart below shows the LTACH bed need for Shelby County, only, and the calculated number for 2020 is inserted in the 3rd column of the requested chart above. The chart below shows the calculations:

	Population		0.5 LTACH bed X (10,000 population)		Currentlicensed & approved beds	Net Need	
	2018	2020	2018	2020	2018	2018	201920
Shelby County	970,212	981,022	49	50	99	(50)	(49)

It is important to note that the requested LTACH bed need for only Shelby County implies that the service area for this project is limited to Shelby County, alone. That implies there is a surplus of 49 beds in 2020 as noted in the chart above.

However, the original submission contained the following statement regarding the project's service area:

> "As the service being provided is very specialized, patients originate from a wide geographic area. The facility's existing service area is primarily Shelby County, Tennessee, plus coterminous counties in Mississippi and Arkansas. A few of our patients originate in some of the western counties in Tennessee and Missouri and Alabama, but not enough to be included in the primary service area. As shown on Attachment B.Need.C, in 2015, approximately 83% of the Applicant's patients from Tennessee originated from Shelby County, approximately 53% of all patients originated from Shelby County, approximately 63% of its patients originated from Tennessee and approximately 37% of its patients came from out of state. Regarding the out of state patients, about 57% originated from Mississippi, and about 40% came from Arkansas. The approval of these relatively few beds is not expected to alter the existing service area of the Applicant."

The Applicant maintains the project's service area to be much larger than Shelby County, Tennessee, as explained in the application. Only about half (53%) of the Applicant's patients originated from Shelby County in 2015, and only 63% of our patients originated from Tennessee, as stated in the quote above. Our primary service area is as originally stated, including Shelby County, Tennessee, plus coterminous counties in Mississippi and Arkansas.

6. **Section B, Need, Item A Section C, Item 1.a. (Long Term Care Hospital Beds-A. Need 2.)**

Please complete the following table for Shelby County LTACH facilities:

Facility	Licensed LTACH Beds	2016 LTACH Patient Days	2016 Licensed LTACH Occupancy
Baptist	30	7041	64.3%
Methodist	36	4808	36,6%*
Select	39	10311	72.4%
Regional Med	24	7160	81.7%
TOTAL	**129**	**29,320**	**62.3%**

*Note: * Methodist is now closed.*

*** Also, since Regional Med staffed only 21 beds historically, the 2016 occupancy rate would have been 93.4% of staffed beds.*

*

7. **Section C, Need, Item 1.a. (Long Term Care Hospital Beds-. B. Economic Feasibility 1.)**

   What is the savings for a typical LTACH hospital stay over short-term general acute care alternative at Regional One Health?

Response: As stated on page 25 of the Application,

> "…the total equivalent inpatient cost per day at Regional One Health is $3,137. The total operating expenses per day for Regional One Health Extended Care Hospital is $1,730. With a daily differential of $1,407 multiplied by the length of stay as reported on the most recently filed cost report of 33.75 days, the savings to retaining the patient at the short term acute care venue would average $47,486 per Medicare patient."

In addition, since our most recent ALOS is 33.75 days, each bed would "turn over" 10.8 times per year. This means that the addition of 24 LTACH beds, operating at 100% utilization with Medicare patients, would result in potential of annual savings to Medicare of $12,308,371.20.

8. **Section C, Need, Item 1.a. (Long Term Care Hospital Beds-B. Economic Feasibility 2.)**

Please complete the following charts for the most recent year available:

Payor	Admissions	% of Total
Medicare	137	69.9
TennCare/Medicaid	11	5.6
Commercial	35	17.9
Self-Pay	2	1.0
Charity Care	0	0.0
Other *WC*	11	5.6
Total	196	100.0

Age Group	Admissions	% of Total
Age 0-17	3	1.5
Age 18-44	56	28.6
Age 45-64	41	20.9
Age 65+	96	49.0
Total	196	100.0

(Note: the most recent year is 2016, and our 2016 fiscal year runs from 07/15/15 – 06/30/16. Further, our records are kept by age groups "under 15," "15-17," "18-64," "65-74," "75-84," and "85 and older." Therefore, there is some rounding on the lower chart above to arrive at 100%.)

9. **Section C, Need, Item 1.a. (Long Term Care Hospital Beds-B. Economic Feasibility 3.)**

   Is the applicant suggesting that because of CMS reimbursement there are not enough potential Charity Care and Medically Indigent LTACH patients to total a 5% charity/medically indigent payor mix? Pease discuss further.

Response: A review of the 4 LTACHs which operated in Memphis in 2016 (Methodist closed on June 30, 2016, and voluntarily surrendered its 39 beds) indicates that:

the Baptist LTACH provided 1.8% of charity care;
the Methodist LTACH provided 0.5% of charity care;
the Select LTACH provided 0.0% of charity care; and
the Applicant (Regional Med Extended Care LTACH) provided 0.2% of charity care.

There is very little reimbursement considering the amount of revenue we receive on any particular patient. If a facility has a relatively small number of beds (and the Applicant has traditionally had the smallest number of LTACH beds of any facility in Memphis), there is not enough profit margin to identify and provide care for a significant number of charity patients. This is especially true when the HSDA definition of charity care is so specific ("those patients who you know, up front, you will not be reimbursed for their care."). Many facilities add their charity care to bad debt and just write off all of it at once, not distinguishing whether or not a patient was a charity patient or a bad debt patient. From a financial standpoint, it matters not to the facility which of those two categories a particular patient falls into: the facility isn't being paid.

Further, note that 99% of the LTACH patients at the Applicant's facility were reimbursed from some program, be it Medicare, TennCare, Commercial Insurance, or Worker's Comp. Only 1% of our LTACH patients in 2016 were self-pay patients, which is the category from which you might expect a charity care patient to be. It is understood in the health care industry that LTACH care is basically a long-term program designed to care for people in specific health care situations that preclude the provision of that care by regular hospitals, and there are many payment mechanisms for those LTACH patients. The 5% charity care goal is not a federal mandate, nor is it mentioned in the Medicare program. This goal was originally set for all LTACHs in Tennessee by the Tennessee State Health Plan when the specific type of care ("LTACH") was originally authorized. The Applicant believes the wording of that goal should be considered for revision.

10. Section C, Need, Item 1.a. (Long Term Care Hospital Beds-C. Orderly Development. 1.)

Please provide the actual average hours per patient per day of rehabilitation provided to the patients of the applicant facility for the most recent year available. Please also do the same with nursing hours.

Response: As stated on pages 45 and 46 of the application,

"In addition, please note that the actual average hours per patient day for rehabilitation for the most recent year available is 0.4 hours (23 minutes) per patient day.

"The actual average hours per patient day for nursing hours for the most recent year available (including productive time for RNs only) are 9.43 hours.

"Due to the acuity of the patient population seen at Regional One Health Extended Care Hospital, the projected nurse staffing hours will be 9.48 (See calculation below) hour per patient day. The projected therapy staffing will be .4 hours per patient day consistent with our actual in the most recent year. Combined nursing and therapy staffing hours per patient day will be 9.88.

"The Applicant will continue to focus on nursing and therapeutic care for our patients, as emphasized in the guidelines for LTACH care. Furthermore, our projected caseload will require no more than three (3) hours per day of rehabilitation."

Utilizing projected staffing patterns and projected patient utilization, please provide the calculations that indicate that patients will be receiving 6-8 hours per patient day of nursing and therapeutic services.

Response: Please see chart below:

Staff	FTE	Production Hrs/Week	Hrs/Week	Weeks/ Yr	Tot Hrs	Pt Days	Hrs/Pt Day
Nursing	85.1	36	3,064	52	159,307	16,805	9.48
Rehab	3.6	36	129	52	6,722	16,805	0.40
Total							9.88

Again, the acuity of our patients requires more nursing hours than would be expected, and we project 9.48 nurse staffing hours per patient day. Our projected rehab staffing is 0.40 hours per patient day.

11. Section C, Need, Item 1.a. (Long Term Care Hospital Beds-A. Orderly Development. 2.)

Please indicate the latest annual average aggregate length of stay as calculated by the Health Care Finance Administration.

Response: Since there is no Health Care Finance Administration, the Applicant assumes you are referring to the ALOS provided by the Applicant to CMS for the latest annual Cost Report. Our last Cost Report showed our ALOS to be 33.75 days, as indicated in the original filing of this application.

In 2016, we admitted 196 patients and provided 7160 patient days of care, resulting in an ALOS of 36.53 days, indicating that our next CMS Cost Report will show the new number.

12. Section C, Need, Item 1.a. (Long Term Care Hospital Beds-A. Orderly Development. 3.)

Please provide historical data from the existing LTACH documenting the average number of hours of rehabilitation per day per patient.

Response: In 2017, we delivered 7,378 patient days of care and incurred 2,951.2 hours of rehabilitation, resulting in 0.4 hours/day of rehabilitation per day per patient. Note that this was in our latest fiscal year (07/01/16 – 06/31/17), not the latest Joint Annual Report.

13. Section B, Need, Item C

Please update the Bed Need Chart on Page 19 of the application to reflect Years 2018 and 2020.

Response: Please see replacement page 19.

14. Section B, Need, Item D.1.

Please update the demographic table on Page 20 reflecting 2018 as the current year and 2020 as the projected year.

Response: Please see replacement pages 20, 22, and 23.

15. Section B, Need, Item E

Your response is noted. Please update the utilization tables on pages 24 and 25 to reflect Years 2014-2016.

Response: Please see replacement pages 24 and 25.

16. Section B, Need, Item F.

Please also complete the following chart for the applicant facility.

Beds	Year 1	Year 1	Year 1	Year 1	Year 2	Year 2	Year 2	Year 2
	Admits	Pat. Days	ALOS	%Occ.	Admits	Pat. Days	ALOS	%Occ.
24 existing	204	7755	38	88.5%	204	7755	38	88.5%
6 Outstanding	48	1810	38	82.6%	48	1810	38	82.6%
24 Proposed	192	7240	38	82.6%	192	7240	38	82.6%
54 Total	444	16805	38	84.6%	444	16805	38	84.6%

17. Section B, Economic Feasibility, Item A.1 Project Cost Chart

The letter from Mr. Wagers indicates that $1,240,000 is a sufficient estimate to complete the 24 bed project; however there are no construction costs in the Project Costs Chart. Please explain.

Response: That amount covers legal/consultant/administrative fees, plus both fixed and moveable equipment costs.

Please show the calculations that led to the determination that the fair market value of the leased space was actually higher than the lease expense over the initial term of the lease.

Response: The remaining term of the existing lease is 5 years, and the annual lease cost is $500,000, resulting in a total lease commitment of $2,500,000. The FMV of the space is $9,000,000. Therefore, the FMV is actually higher than the lease expense for this project.

The request for an $1,840 refund is noted and is being processed. Please submit a revised Project Costs Chart that reflects the corrected filing fee.

Response: Thank you. As a matter caution since the Applicant did not know if a refund would be available, the total amount of the filing fee check was included in the original submission. Please see replacement page 28.

18. Section B, Economic Feasibility, Item C – Projected Data Chart

Since this application will not be heard by the Agency any sooner than April 2018 and the applicant's Project Completion Chart indicates the beds will not go into service until August 2018, please submit a revised Projected Data Charts that reflect Years 2019 and 2020.

Response: Ignoring the fact that our fiscal year is different from the calendar year, we prefer to utilize "Year 1" and "Year 2" as the column designations. However, at your request, we will add the numbers 2019 and 2020 to these columns, even though the actual years may be different. Please see replacement pages 33 through 36.

For the Total Facility Projected Data Chart, there are miscalculations in the Year 1 column.

Response: The original submission of the Projected Data Chart for the Total Facility was incorrect. Please note the changes on pages 33 and 34.

For the Project Only Projected Data Chart, there are miscalculations in the Year 1 column and there is a typo in the "Supplies" line in Year 2.

Response: Please see replacement pages 35 and 36.

Please explain how the rent for the Project Only will be $500,000 in Year 1 since the Option to Lease indicates the rent will be $125,000 annually.

Response: The rent for the project only will be $500,000 in Year 1, and the new Option to Lease reflects that number.

19. Section B, Economic Feasibility, Item F – Item 3 Capitalization Ratio

The capitalization ratio of 0.15% is noted. However, the ratio appears to calculate at 14.68%. Please clarify.

Response: You are correct, and 14.68% is the correct calculation. We misplaced the decimal point and committed a rounding error in the original submission.

20. Section B, Orderly Development, Item D (1))

The facility license provided by the applicant expired December 2, 2017. Please provide a copy of the facility license that is current.

Response: Please see Supplemental B.OD.D.1.

21. Section B. Quality Measures

Please discuss the applicant's commitment to the proposal in meeting appropriate quality standards by addressing each of the following factors:

(a) Whether the applicant commits to maintaining an actual payor mix that is comparable to the payor mix projected in its CON application, particularly as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent;

Response: The Applicant so commits.

(b) Whether the applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;

Response: The Applicant so commits.

(c) Whether the applicant will obtain and maintain all applicable state licenses in good standing;

Response: The Applicant so commits.

(d) Whether the applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;

Response: The Applicant so commits.

(e) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;

Response: The Applicant so commits.

(f) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

Response: The Applicant so commits it has not been decertified.

(g) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

Response: The Applicant so commits.

(h) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

Response: The Applicant so commits.

(i) 1. This may include accreditation by any organization approved by Centers for Medicare and Medicaid Services (CMS) and other nationally recognized programs. The Joint Commission or its successor, for example, would be acceptable if applicable.

Response: The Applicant so commits to continue accreditation by CMS for Medicare. However, there is no requirement that LTACHs obtain Joint Commission accreditation.

In addition, we realized that we had not allocated all of the time available to us for hospital projects, and changed the Projected Completion Chart (and any references to project completion) to ensure we could use all of the three years available to us for hospital CON projects. To that extent, we changed pages 5, 26, 39, and 53.

Supplemental #1
January 29, 2018
2:07 PM

OPTION TO LEASE

For and in consideration of $1.00, cash in hand paid, the receipt of which is hereby acknowledged, and other good and valuable consideration, Shelby County Health Care Corporation, d/b/a Regional One Health ("ROH") hereby bargains, sells and grants to Regional MED Extended Care Hospital, LLC ("The LTACH"), its successors and assigns, the right and option to amend the current Lease Agreement between the parties dated September 23, 2013 (the "Lease"), to add an additional 24 beds and support space located on the third floor (3rd) floor of Turner Tower on the campus of ROH (the "Premises") to expand the LTACH's operation of a long term acute care hospital from thirty (30) beds to fifty-four (54) beds. The terms and conditions of the amendment to the Lease to be executed by and between the parties (the "Amendment") shall be in accordance with the terms and conditions set forth in this option and the Lease. If there is any conflict between the provisions of this Option to Lease and the Amendment, the provisions of the Amendment shall prevail. The LTACH must provide notice to ROH of its intention to exercise this Option, as provided below.

It is anticipated that the Amendment, when executed, shall be co-terminus with the Lease at an additional cost to The LTACH of Five Hundred Thousand Dollars ($500,000) per year, and such Amendment shall be executed not later than three years after The LTACH receives approval of a Certificate of Need from the Tennessee Health Services and Development Agency for its hospital to be expanded in the Premises. If The LTACH does not file a Certificate of Need within ninety (90) days of execution of this Option to Lease, this Option to Lease shall terminate and be of no further force and effect. If The LTACH's Certificate of Need application is petitioned for a Contested Case Hearing, this Option to Lease shall continue in effect until ten (10) days following any favorable decision on the Contested Case Hearing. If the parties fail to reach agreement as to the terms and conditions of the Amendment within thirty (30) days after The LTACH gives notice of its intent to exercise its Option to Lease, then this Option shall terminate and be of no further force and effect.

The provisions of this Option shall be binding upon and inure to the benefit of both parties and their respective heirs, successors and assigns.

This Option shall be construed in accordance with and governed by the laws of the State of Tennessee. Time is expressly declared to be of the essence of this Option.

IN WITNESS WHEREOF, the parties have signed this option on this 11th day of January, 2018.

SHELBY COUNTY HEALTH CARE CORPORATION

BY: _____
J. Richard Wagers, Sr. EVP/CFO

Regional MED Extended Care Hospital, LLC

BY: _____
Mark A. Kelly, CEO/Administrator

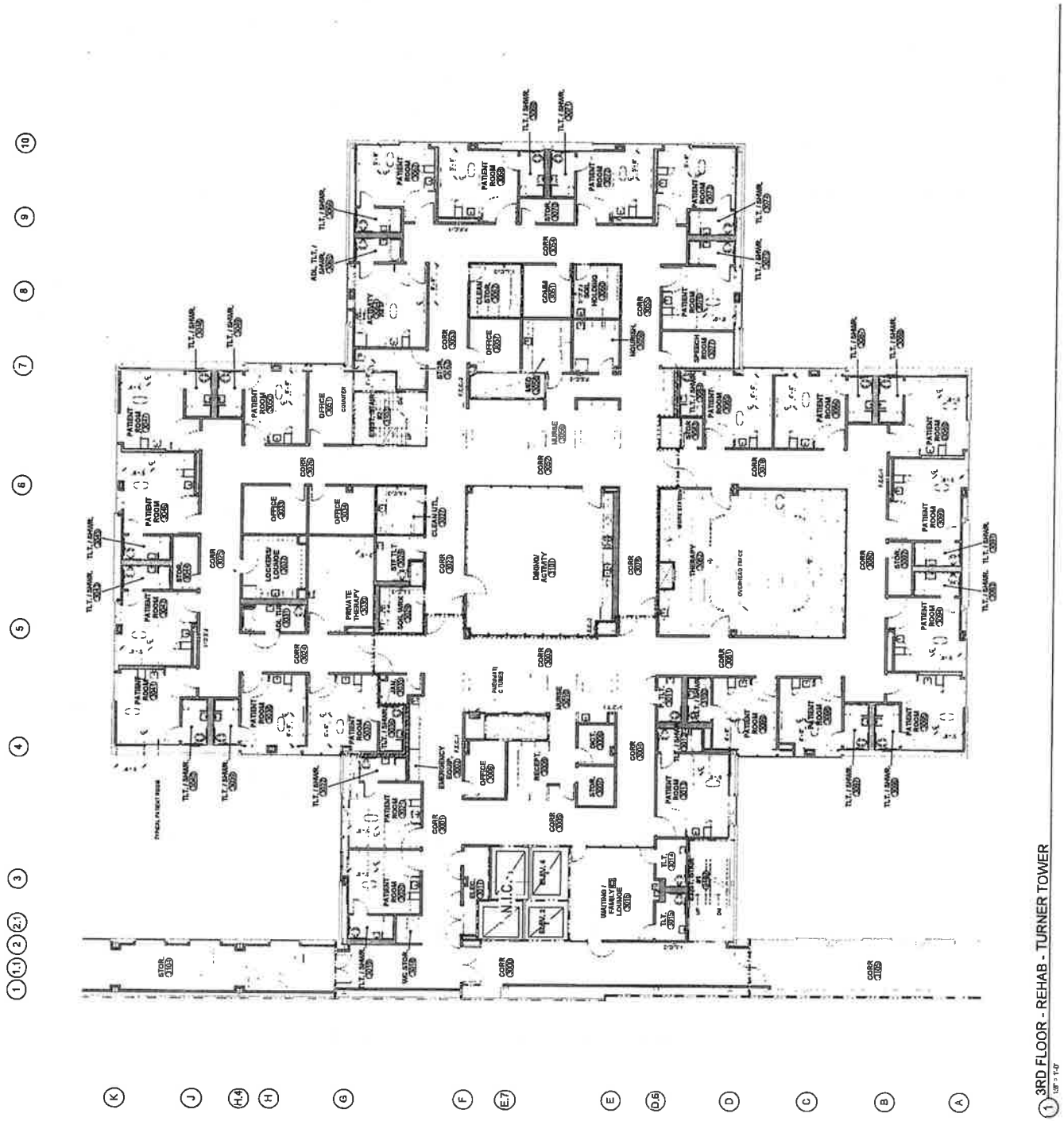
ANF ARCHITECTS

APM AMERICAN PROGRAM MANAGEMENT

218 SUPPLEMENTAL 3RD FLR FOOTPRINT

Supplemental #1
January 29, 2017
2:07 PM

PLANNING
REGIONAL ONE
877 JEFFERSON AVE MEMPHIS TN
TURNER TOWER RENOVATION
3RD FLOOR PLAN - TURNER TOWER
A230



Board for Licensing Health Care Facilities

State of Tennessee

0000000186

No. of Beds 0024

DEPARTMENT OF HEALTH

This is to certify, that a license is hereby granted by the State Department of Health to

REGIONAL MED EXTENDED CARE HOSPITAL, LLC *to conduct and maintain a*

Hospital REGIONAL ONE HEALTH EXTENDED CARE HOSPITAL

Located at 890 MADISON AVENUE, 4TH FLOOR, MEMPHIS

County of SHELBY *, Tennessee.*

This license shall expire DECEMBER 02 , 2018 , *and is subject to the provisions of Chapter 11, Tennessee Code Annotated. This license shall not be assignable or transferable, and shall be subject to revocation at any time by the State Department of Health, for failure to comply with the laws of the State of Tennessee or the rules and regulations of the State Department of Health issued thereunder.*

In Witness Whereof, we have hereunto set our hand and seal of the State this 26TH *day of* OCTOBER , 2017 .

In the Distinct Category(ies) of: CHRONIC DISEASE HOSPITAL
PEDIATRIC BASIC HOSPITAL

By Vincent J. Dario, MPH
DIRECTOR, DIVISION OF HEALTH CARE FACILITIES

By
COMMISSIONER

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: Regional One Extended Care Facility, CN1801-003

I, E. Graham Baker, Jr., after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge, information and belief.

E. Graham Baker, Jr.
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 01st day of January, 2018, witness my hand at office in the County of Davidson, State of Tennessee.

N. Kathleen Baker
NOTARY PUBLIC

My commission expires 07/05, 2021.

N. Kathleen Baker
State of Tennessee Notary Public
Davidson County

HF-0043

Revised 7/02

Supplemental #2 (Copy)

Regional One Extended Care Hospital

CN1801-003

1. **Section A, Executive Summary, Overview, A.1.**

Your response regarding the 25% rule is noted. If and when this rule is put into effect, what would be the expected reimbursement adjustment for patients from the host hospital that were above the 25% limitation?

Response: For discharges which occur beyond the threshold percentage applicable to the facility, reimbursement would be the lesser of a payment based on the LTACH DRG or an amount equivalent to what CMS would have paid under the short term acute care payment structure. Specifically, there would be a 40% reduction in reimbursement.

While we do not anticipate the imposition of the threshold rule, should it be imposed, the impact may be $3,026,710. This was calculated by taking the Net Revenue of $30,267,099 times 25% times 40%. Please see calculation below.

$30,267,099 times 25% = $7,566,775 times 40% = $3,026,710.

We do not believe this threshold rule will be imposed any time soon due to the reimbursement changes that are addressed in Question #4 of these Supplemental Responses. In addition, even if the threshold rule is implemented and we lose the maximum amount mentioned above, we will still have a positive cash flow and can continue to provide this needed care.

2. Section A, Project Details, Item 6B-(2) Floor Plan

The floor plan for the 3rd floor is noted. There only appears to be 23 rooms identified as patient rooms. Will there be 23 or 24 patient rooms on the 3rd floor?

Response: There are 24 patient rooms on the 3rd floor. The copy that was originally submitted incorrectly labeled room 3064 as a converted activity room. In fact, room 3064 is a patient room. Attached is a Revised Supplemental 3rd Floor which does list all 24 patient rooms.

3. Section B, Need, Item E

The replacement page 25 is noted. The table indicates that LTACH patient days in the service area increased 18.25% between 2014 and 2016; however, they decreased 17.8% during that time period.

Please make the necessary changes and submit a revised replacement page 25.

Response: Please see revised replacement page 25.

4. Section B, Need, Item F.

Your response to this item is noted. It is understood that the additional 24 beds are being requested to accommodate additional demand for these beds; however, in 2016 the applicant reports 7,041 patient days and in Year 1 after the 6 outstanding beds and the 24 proposed beds are in place, patient days are projected to be 16,805 patient days, a 139% increase over 2016.

Additionally, it is understood that Methodist closed its 36 bed unit in 2016 which accounts for that facility's decline in patient days and that Select Specialty chose not to implement its CON to add 28 beds; however other than Regional MED that was ramping up its service starting in 2014, the other LTACH providers reported declines in patient days. In fact, overall LTACH patient days declined 17.8% between 2014 and 2016.

Please provide the assumptions and detailed calculations on how the applicant expects to realize this level of projected growth.

Response: Historically, there has been some concern that some LTACHs should be providing care to a greater mix of higher acuity level patients in this post-acute setting. To remedy this, nearly 2 years ago CMS established new medical acuity criteria in order for LTACHs to receive the 100% LTACH reimbursement rate. Without going into all the changes in the program, part of this change will eventually require that at least fifty percent (50%) of the hospital's LTACH patients meet these new acuity criteria in order to receive payment for any patients at the 100% LTACH rate. Currently, however, many LTACHs are struggling to maintain profitability at high census levels with only 50% of patients at full LTACH reimbursement. Further, many older LTACHs were not developed to provide care for a > 50% mix of these higher acuity patients, who require nearly ICU level nursing care. However, the Applicant opened and was developed to be able to accommodate this particular high acuity level of medical care, given that our host hospital, Regional One Health, is a Level I Trauma Center and Burn Center which refers very sick patients to us. In fact, over 80% of our patients consistently qualify for the full LTACH reimbursement, and thus our case mix index has increased from 1.3 to 1.6 since the new CMS rules were implemented nearly 2 years ago. Further, our occupancy rate is increasing as others in the market have not been able to change their care models to accommodate this higher mix of high acuity patient. As such, the other LTACHs in Memphis are experiencing decreasing reimbursement levels and/or their occupancy rates are decreasing to maintain the 50% high acuity criteria.

Those LTACHs maintaining at least a 50% high acuity mix through 2020, will be receive 100% LTACH reimbursement for all patients in 2021. Prior to 2021, the Applicant will continue to be able to accommodate more of these high acuity level patients than other LTACHSs in the community, plus this project will enable us to be able to afford a higher mix of the lower acuity level patients that are simply not receiving care elsewhere in an LTACH. Once we receive 100% LTACH reimbursement for all patients in 2021, we will be able to accommodate even more lower acuity level patients.

5. **Section B, Economic Feasibility, Item A.1 Project Cost Chart**

   Your response to this item is noted. You have indicated that the FMV of the space is $9,000,000; however, the replacement Project Cost Chart indicates that the FMV is $6,210,000.

   Please address this discrepancy.

Response: You are correct. The Applicant's contact confused two numbers in the Supplemental Response: (1) the estimated total project cost (originally reported as approximately $9,000,000, later reduced to $8,680,000); and (2) the FMV of the space allocated for the 24 beds on the 3rd floor of Turner Tower ($6,210,000). The Project Cost Chart is correct as submitted. The Supplemental Response should have read as follows:

> "The remaining term of the existing lease is 5 years, and the annual lease cost is $500,000, resulting in a total lease commitment of $2,500,000. The FMV of the space is $6,210,000. Therefore, the FMV is actually higher than the lease expense for this project."

Supplemental #2
Revised Supplemental 3rd Floor
January 31, 2018
10:22 A.M.

ANF ARCHITECTS

APM AMERICAN PROGRAM MANAGEMENT

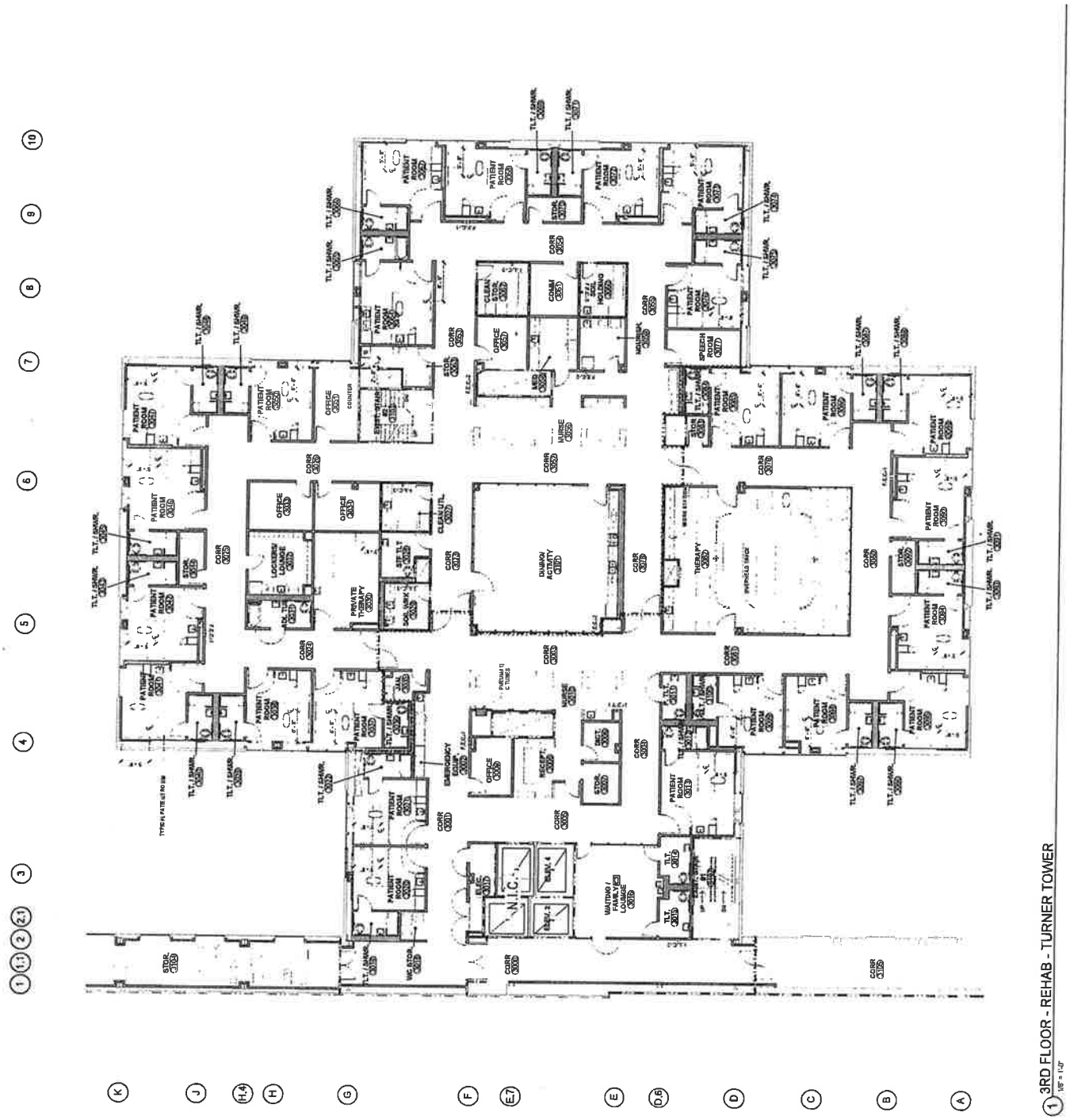
PLANNING
REGIONAL OP

877 JEFFERSON AVE.
MEMPHIS, TN

TURNER TOWER RENOVATION

3RD FLOOR PLAN - TURNER TOWER

A230



Supplemental #2
January 31, 2018
10:22 A.M.

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: Regional One Extended Care Facility, CN1801-003

I, E. Graham Baker, Jr., after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge, information and belief.

E. Graham Baker, Jr.
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 30th day of January, 2018, witness my hand at office in the County of Davidson, State of Tennessee.

N. Kathleen Baker
NOTARY PUBLIC

My commission expires JULY 05, 2021.

N. Kathleen Baker
State of Tennessee Notary Public
Davidson County

HF-0043

Revised 7/02

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Commercial Appeal which is a newspaper of general circulation in Shelby County, Tennessee, on or before January 10, 2018, for one day.

==========

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that Regional MED Extended Care Hospital, LLC, d/b/a Regional One Health Extended Care Hospital ("Applicant"), 890 Madison Avenue, 4th Floor, Memphis (Shelby County), Tennessee 38103, a licensed twenty-four (24) bed hospital (with six [6] additional beds approved in December, 2017) providing Long Term Acute Care Hospital ("LTACH") services, owned by Shelby County Health Care Corporation, with the Applicant having an ownership type of Limited Liability Company and the owner having an ownership type of corporation, intends to file a Certificate of Need application for the addition of twenty-four (24) hospital beds limited to LTACH services. The requested twenty-four (24) additional beds will be housed on the 3rd floor of the existing building, and will be licensed by the Tennessee Department of Health as hospital beds. There is no major medical equipment involved with this project. No other health services will be initiated or discontinued. The estimated project cost is anticipated to be approximately $9,000,000.00.

The anticipated date of filing the application is: January 12, 2018.

The contact person for this project is E. Graham Baker, Jr., Attorney, who may be reached at Anderson & Baker, 2021 Richard Jones Road, Suite 120, Nashville, TN 37215, 615/370-3380.

E. Graham Baker, Jr. (Signature) 01/10/2018 (Date) graham@grahambaker.net (E-mail Address)

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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RULES
OF
HEALTH SERVICES AND DEVELOPMENT AGENCY

CHAPTER 0720-11
CERTIFICATE OF NEED PROGRAM – GENERAL CRITERIA

TABLE OF CONTENTS

0720-11-.01 GENERAL CRITERIA FOR CERTIFICATE OF NEED. The Agency will consider the following general criteria in determining whether an application for a certificate of need should be granted:

(1) Need. The health care needed in the area to be served may be evaluated upon the following factors:

(a) The relationship of the proposal to any existing applicable plans;

(b) The population served by the proposal;

(c) The existing or certified services or institutions in the area;

(d) The reasonableness of the service area;

(e) The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants, and low-income groups;

(f) Comparison of utilization/occupancy trends and services offered by other area providers;

(g) The extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet these needs.

(2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:

(a) Whether adequate funds are available to the applicant to complete the project;

(b) The reasonableness of the proposed project costs;

(c) Anticipated revenue from the proposed project and the impact on existing patient charges;

(d) Participation in state/federal revenue programs;

(e) Alternatives considered; and

(f) The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.

(Rule 0720-11-.01, continued)

(3) Quality. Whether the proposal will provide health care that meets appropriate quality standards may be evaluated upon the following factors:

(a) Whether the applicant commits to maintaining an actual payor mix that is comparable to the payor mix projected in its CON application, particularly as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent;

(b) Whether the applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;

(c) Whether the applicant will obtain and maintain all applicable state licenses in good standing;

(d) Whether the applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;

(e) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;

(f) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

(g) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

1. This may include accreditation by any organization approved by Centers for Medicare and Medicaid Services (CMS) and other nationally recognized programs. The Joint Commission or its successor, for example, would be acceptable if applicable. Other acceptable accrediting organizations may include, but are not limited to, the following:

(i) Those having the same accrediting standards as the licensed hospital of which it will be a department, for a Freestanding Emergency Department;

(ii) Accreditation Association for Ambulatory Health Care, and where applicable, American Association for Accreditation of Ambulatory Surgical Facilities, for Ambulatory Surgical Treatment Center projects;

(iii) Commission on Accreditation of Rehabilitation Facilities (CARF), for Comprehensive Inpatient Rehabilitation Services and Inpatient Psychiatric projects;

(iv) American Society of Therapeutic Radiation and Oncology (ASTRO), the American College of Radiology (ACR), the American College of Radiation Oncology (ACRO), National Cancer Institute (NCI), or a similar accrediting authority, for Megavoltage Radiation Therapy projects;

(v) American College of Radiology, for Positron Emission Tomography, Magnetic Resonance Imaging and Outpatient Diagnostic Center projects;

(Rule 0720-11-.01, continued)

(vi) Community Health Accreditation Program, Inc., Accreditation Commission for Health Care, or another accrediting body with deeming authority for hospice services from CMS or state licensing survey, and/or other third party quality oversight organization, for Hospice projects;

(vii) Behavioral Health Care accreditation by the Joint Commission for Nonresidential Substitution Based Treatment Center, for Opiate Addiction projects;

(viii) American Society of Transplantation or Scientific Registry of Transplant Recipients, for Organ Transplant projects;

(ix) Joint Commission or another appropriate accrediting authority recognized by CMS, or other nationally recognized accrediting organization, for a Cardiac Catheterization project that is not required by law to be licensed by the Department of Health;

(x) Participation in the National Cardiovascular Data Registry, for any Cardiac Catheterization project;

(xi) Participation in the National Burn Repository, for Burn Unit projects;

(xii) Community Health Accreditation Program, Inc., Accreditation Commission for Health Care, and/or other accrediting body with deeming authority for home health services from CMS and participation in the Medicare Quality Initiatives, Outcome and Assessment Information Set, and Home Health Compare, or other nationally recognized accrediting organization, for Home Health projects; and

(xiii) Participation in the National Palliative Care Registry, for Hospice projects.

(h) For Ambulatory Surgical Treatment Center projects, whether the applicant has estimated the number of physicians by specialty expected to utilize the facility, developed criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel, and documented the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

(i) For Cardiac Catheterization projects:

1. Whether the applicant has documented a plan to monitor the quality of its cardiac catheterization program, including but not limited to, program outcomes and efficiencies;

2. Whether the applicant has agreed to cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee, which may be developed per Policy Recommendation; and

3. Whether the applicant will staff and maintain at least one cardiologist who has performed 75 cases annually averaged over the previous 5 years (for an adult program), and 50 cases annually averaged over the previous 5 years (for a pediatric program).

(j) For Open Heart projects:

1. Whether the applicant will staff with the number of cardiac surgeons who will perform the volume of cases consistent with the State Health Plan (annual average of the previous 2 years), and whether the applicant will maintain this volume in the future;

2. Whether the applicant will staff and maintain at least one surgeon with 5 years of experience;

3. Whether the applicant will participate in a data reporting, quality improvement, outcome monitoring, and peer review system that benchmarks outcomes based on national norms, with such a system providing for peer review among professionals practicing in facilities and programs other than the applicant hospital (demonstrated active participation in the STS National Database is expected and shall be considered evidence of meeting this standard);

(k) For Comprehensive Inpatient Rehabilitation Services projects, whether the applicant will have a board-certified physiatrist on staff (preferred);

(l) For Home Health projects, whether the applicant has documented its existing or proposed plan for quality data reporting, quality improvement, and an outcome and process monitoring system;

(m) For Hospice projects, whether the applicant has documented its existing or proposed plan for quality data reporting, quality improvement, and an outcome and process monitoring system;

(n) For Megavoltage Radiation Therapy projects, whether the applicant has demonstrated that it will meet the staffing and quality assurance requirements of the American Society of Therapeutic Radiation and Oncology (ASTRO), the American College of Radiology (ACR), the American College of Radiation Oncology (ACRO), National Cancer Institute (NCI), or a similar accrediting authority;

(o) For Neonatal Intensive Care Unit projects, whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system; whether the applicant has documented the intention and ability to comply with the staffing guidelines and qualifications set forth by the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities; and whether the applicant will participate in the Tennessee Initiative for Perinatal Quality Care (TIPQC);

(p) For Nursing Home projects, whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems, including in particular details on its Quality Assurance and Performance Improvement program. As an alternative to the provision of third party accreditation information, applicants may provide information on any other state, federal, or national quality improvement initiatives;

(q) For Inpatient Psychiatric projects:

1. Whether the applicant has demonstrated appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems and children who need quiet space; proper sleeping and bathing arrangements for all patients), adequate staffing (i.e., that each unit will be staffed with at least two direct patient care staff, one of which shall be a nurse, at all

times), and how the proposed staffing plan will lead to quality care of the patient population served by the project;

2. Whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system; and

3. Whether an applicant that owns or administers other psychiatric facilities has provided information on satisfactory surveys and quality improvement programs at those facilities.

(r) For Freestanding Emergency Department projects, whether the applicant has demonstrated that it will satisfy and maintain compliance with standards in the State Health Plan;

(s) For Organ Transplant projects, whether the applicant has demonstrated that it will satisfy and maintain compliance with standards in the State Health Plan; and

(t) For Relocation and/or Replacement of Health Care Institution projects:

1. For hospital projects, Acute Care Bed Need Services measures are applicable; and

2. For all other healthcare institutions, applicable facility and/or service specific measures are applicable.

(u) For every CON issued on or after the effective date of this rule, reporting shall be made to the Health Services and Development Agency each year on the anniversary date of implementation of the CON, on forms prescribed by the Agency. Such reporting shall include an assessment of each applicable volume and quality standard and shall include results of any surveys or disciplinary actions by state licensing agencies, payors, CMS, and any self-assessment and external peer assessment processes in which the applicant participates or participated within the year, which are relevant to the health care institution or service authorized by the certificate of need. The existence and results of any remedial action, including any plan of correction, shall also be provided.

(v) HSDA will notify the applicant and any applicable licensing agency if any volume or quality measure has not been met.

(w) Within one month of notification the applicant must submit a corrective action plan and must report on the progress of the plan within one year of that submission.

(4) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective health care system may be evaluated upon the following factors:

(a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);

(b) The positive or negative effects attributed to duplication or competition; and

(Rule 0720-11-.01, continued)

(c) The availability and accessibility of human resources required by the proposal, including consumers and related providers.

(5) Applications for Change of Site. When considering a certificate of need application which is limited to a request for a change of site for a proposed new health care institution, The Agency may consider, in addition to the foregoing factors, the following factors:

(a) Need. The applicant should show the proposed new site will serve the health care needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change to the proposed new site.

(b) Economic factors. The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.

(c) Quality of Health Care to be provided. The applicant should show the quality of health care to be provided will be served at least as well as the original site.

(d) Contribution to the orderly development of health care facilities and/or services. The applicant should address any potential delays that would be caused by the proposed change of site, and show that any such delays are outweighed by the benefit that will be gained from the change of site by the population to be served.

(6) Certificate of need conditions. In accordance with T.C.A. § 68-11-1609, The Agency, in its discretion, may place such conditions upon a certificate of need it deems appropriate and enforceable to meet the applicable criteria as defined in statute and in these rules.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 68-11-1605, 68-11-1609, and 2016 Tenn. Pub. Acts Ch. 1043.* ***Administrative History:*** *Original rule filed August 31, 2005; effective November 14, 2005. Emergency rule filed May 31, 2017; effective through November 27, 2017.*

CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING AND ASSESSMENT
615-741-1954

DATE: March 31, 2018

APPLICANT: Regional Med Extended Care Hospital, LLC
d/b/a Regional One Health Extended Care Hospital
890 Madison Avenue, 4th Floor
Memphis Tennessee 38103

CON: CN-1801-003

CONTACT PERSON: Graham Baker, Jr.
2120 Richard Jones Road
Nashville, Tennessee 37215

COST: $8,680,000

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's State Health Plan*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:

The applicant, Regional Med Extended Care Hospital, LLC, d/b/a Regional One Health Extended Care Hospital, located at 890 Madison Avenue, 4th Floor, Memphis, Tennessee 38103, a licensed 24-bed hospital providing Long Term Acute Care Hospital (LTACH) services, owned by Shelby County Health Care Corporation, with the applicant having an ownership type of Limited Liability Company and the owner having an ownership type of corporation, and to be managed by Murer Consultants, Inc., 19065 Hickory Creek Drive, Suite 115, Mokena, Illinois, seeks Certificate of Need (CON) approval for the addition of twenty-four (24) hospital beds limited to LTACH services, with 6 additional unimplemented beds approved with CON # CN-1708-025A in December. The requested 24 beds will be housed on the 3rd floor of the existing building and will be licensed by the Tennessee Department of Health as hospital beds. There is no major medical equipment involved with the project and no other health services will be initiated or discontinued. Also, no completed square footage chart was included as there will be neither construction nor renovation involved with the project.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

NEED:

The applicant's existing service area is primarily Shelby County, Tennessee, plus coterminous counties in Mississippi and Arkansas.

The 2018 Shelby County population is 970,212, increasing to 981,022 in 2020, an increase of 1.1%.

According to the applicant, in 2015, approximately 83% of their patients from Tennessee originated from Shelby County, approximately 53% of all patients originated from Shelby County, approximately 63% of its patients originated from Tennessee and 37% of its patients came from out of state. Of the out of state patients, 57% originated from Mississippi and about 40% from Arkansas. According to the 2016 Joint Annual Report for Hospitals (JAR), 50% of Tennessee patients originated from Shelby County.

The applicant seeks to add twenty-four beds within a physical space that provides for more efficient care coordination for the hospital and patients and to permit greater access to care for this highly acute patient population with a need for extended acute care stay. The applicant is part of an organization that serves as a Level One Trauma Center and Regional Burn Center and has a high need for long term acute care services within its post-acute compliment. Patients with extended care needs related to ventilator management and weaning are best served in long term care environments; with Regional One Health Extended Care Hospital demonstrating vent weaning well below the national average.

Methodist Hospital closed its 36-bed LTACH recently and now refers their long term care patients to the applicant. Also, Select Specialty Hospital, another LTACH in Memphis, recently voluntarily surrendered its approved CON # CN-1212-062, which was approved in May 2013, for an additional 28 beds. Furthermore, searching the American Hospital Directory, there are only three LTACHs within 75 miles of zip code 38103 (the Applicant's zip code), and all three are in Memphis (Shelby County): Baptist Memorial Restorative Care Hospital with 30 beds, Regional One Health Extended Care Hospital with 24 beds, and Select Specialty Hospital with 39 beds. Expanding that search to 100 miles, there is only one additional LTACH to the above, which is Advanced Care Hospital of White County, which has 27 beds in Searcy, Arkansas. Expanding that search to 120 miles, there is one more additional LTACH, which is AMG Specialty Hospital of Greenwood, which has 40 beds in Greenwood, Mississippi.

From 2014 to 2016, LTACH patient days declined 17.8%. However, the applicant is expecting to reach a projected growth of 16,805 patient days, which would be a 139% increase over their numbers in 2016. The applicant is expecting the aforementioned growth for a number of reasons. Historically, there has been some concern that some LTACHs should be providing care to a greater mix of higher acuity level patients in this post-acute setting. In response to this, nearly two years ago, CMS established new medical acuity criteria in order for LTACHs to receive the 100% reimbursement rate, one of which is that at least 50% of the hospital's LTACH patients meet these new acuity criteria in order to receive 100% reimbursement for all patients. Many of the older LTACHs were not developed to provide care for a 50% mix of these higher acuity patients who may require nearly ICU level nursing care. However, the applicant was developed to be able to accommodate this particular high acuity level of medical care because the applicant's host hospital, Regional One Health, is a Level 1 Trauma and Burn Center, which refers very sick patients. Over 80% of the applicant's patients consistently qualify for the full LTACH reimbursement, increasing their case mix from 1.3 to 1.6 since the implementation of the new CMS rules. Furthermore, the applicant's occupancy rate is increasing as others in the market have not been able to change their care models to accommodate the higher mix of high acuity patients. Therefore, other LTACHs in Memphis are experiencing decreasing reimbursement levels and their occupancy is decreasing to maintain the 50% high acuity rate.

The LTACHs maintaining at least a 50% high acuity mix through 2020 will receive 100% reimbursement for all patients in 2021. Prior to 2021, the applicant will continue to be able to accommodate more of the high acuity patients than any other LTACH in the community. The added benefit is that the project will enable the applicant to afford a higher mix of lower acuity level patients that are simply not receiving care elsewhere in an LTACH. The 100% reimbursement in 2021 will enable the applicant to accommodate even more lower acuity level patients.

The following charts illustrate the 2013-2016 LTACH Utilization Trends in the service area.

Facility	***Licensed Beds***	***2013 Admns***	***2014 Admns***	***2015 Admns***	***2016 Admns***	***2013 ALOS***	***2014 ALOS***	***2015 ALOS***	***2016 ALOS***
Baptist	*30*	*286*	*259*	*250*	*214*	*34.5*	*32.8*	*33.4*	*32.9*
Methodist*	*36*	*426*	*435*	*424*	*172*	*26.4*	*27.0*	*27.1*	*12.9*
Select Specialty**	*39*	*448*	*422*	*265*	*344*	*28.6*	*32.5*	*50.5*	*30.0*
Regional Med	*24*	*n/a*	*63*	*181*	*196*	*n/a*	*27.2*	*37.9*	*36.5*
Total	*129*	*1160*	*1179*	*1120*	*926*	*29.2*	*30.3*	*35.8*	*31.7*

	2018	*2020*	*2018 LTAC Bed Need*	*2020 LTAC Bed Need*	*2018 Beds*	*2018 Net Need*	*2020 Net Need*
Shelby County	*970,212*	*981,022*	*49*	*49*	*93*	*(44)*	*(44)*

*Methodist Hospital closed its 36-bed LTACH recently and now refers their long term care patients to the applicant.
**Select Specialty Hospital, another LTACH in Memphis, recently voluntarily surrendered its approved CON 1212-062 for an additional 28 beds.

The Department of Health, Division of Policy, Planning, and Assessment calculated the LTACH bed need for Shelby County to be a surplus of 44 beds.

TENNCARE/MEDICARE ACCESS:

The applicant participates in the Medicare and TennCare/Medicaid programs and contract with Tenn/Care MCOs AmeriGroup, United Health/care Community Plan, BlueCare, and TennCare Select. The applicant's Medicare Provider Number is 44-2017 and Medicaid Provider Number is Q019830. During the 1980s, LTACHs were created to allow hospitals to discharge medically complex patients from their facilities in order to decrease Medicare spending. The long term acute venue was designed, and is reimbursed by Medicare to provide an appropriate venue for this acutely ill patient population, requiring an extended length acute care stay, within the continuum of care. When LTACHs were first established in Tennessee, the state designed criteria and standards which included a provision that "… a minimum of 5% of the patient population using long term acute care beds will be charity or indigent care." Also, the Medicare 25 percent threshold policy is a per discharge payment adjustment to the LTACH PPS that is applied to payments for Medicare patient discharges when the number of patients originating from any single referring hospital is in excess of 25 percent of the total Medicare discharges. If the LTACH exceeds the threshold during the current cost reporting period, payment of the discharge that puts the LTACH over the 25% threshold and all discharges subsequent to that discharge are subject to an adjusted reimbursement. The applicant does not expect more than 25% of discharges from any one hospital. Additionally, the long term acute care hospital is owned by Shelby County Health Care Corporation which as a disproportionate share hospital (DSH), serves a large percentage of charity care patients. As a DSH, Regional One Health is, in turn, reimbursed for the care provided to this patient population. The long term acute hospital is not eligible for this disproportionate share allocation to serve the unfunded patient population.

The approval of this application will increase the number of LTACH beds at the facility. The applicant claims that this will strengthen the financial viability, and the ability to serve the community and mission of the health system. The applicant projects total facility Year One Medicare revenues of $9,926,847 or 66.9% of total gross revenues and TennCare revenues of $1,493,828 or 10.1% of total gross revenues.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:
The Department of Health, Division of Policy, Planning, and Assessment have reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine if they are mathematically accurate and if the projections are based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Cost Chart is located in Supplemental 1, Page 28R of the application. The estimated project cost was initially anticipated to be $9,000,000, but was later reduced to $8,680,000, including the filing fee. The majority of these costs involve ongoing lease costs. Very few "new" resources are required for the project, which will be integrated into an existing lease, which expires in September, 2018. The remaining term of the existing lease is 5 years, and the annual lease cost is $500,000, resulting in a total lease commitment of $2,500,000. The FMV of the space is $6,210,000. Therefore, the FMV is actually higher than the lease expense for this project. In that estimated total project cost of $8,680,000, $7,440,000 represents the Fair Market Value of the lease, and the remaining amount will be paid with cash reserves of the applicant. The additional $1,240,000 will go toward legal, consultant, and administrative fees in addition to both fixed and moveable equipment costs.

Historical Data Chart: The Historical Data Chart, covering years 2015 – 2017, is located on page 30 of the application. The applicant reports 6,864, 7,160 and 7,378 patient days with net operating income of $3,335,216, $642,381, and $634,500 each year, respectively.

Projected Data Chart (Total Facility): The Projected Data Chart for the total facility is located on page 30. The applicant projects 16,805 patient days in years one and two, with net operating revenues of $8,352,258 and $7,915,309 each year, respectively.

Projected Data Chart (Project Only): The Projected Data Chart for the project only is located on page 35R. The applicant projects 7,240 patient days in years one and two, with net operating revenues of $6,243,000 and $6,108,340 each year, respectively.

Proposed Charge Schedule

	Previous Year (2016)	Current Year (2017)	Year One	Year Two	% Change
Gross Charge	7,616.63	8,499.58	8,197.13	8,197.13	-3.6
Average Deduction	5,794.47	6,683.20	6,399.79	6,399.79	-4.2
Average Net Charge	1,822.16	1,816.38	1,797.34	1,797.34	-1.0

The following charts represent the applicant's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients that will be served by the project. Additionally, the tables represent the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project:

Historical

Payor Source	Projected Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care	41,937,308	66.9
TennCare/Medicaid	6,310,878	10.1
Commercial/Other Managed Care	12,637,108	20.2
Self-Pay	119,605	0.2
Worker's Comp	1,705,005	2.7
Charity Care	0	0
Total	62,709,904	100

Project Payor Mix - Year One

Payor Source	Projected Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care	39,678,268	66.8
TennCare/Medicaid	5,975,312	10.1
Commercial/Other Managed Care	11,846,052	20
Self-Pay	113,244	0.2
Worker's Comp	1,603,772	2.6
Charity Care	151,352	0.3
Total	$59,368,000	100

Total Facility Payor Mix - Year One

Payor Source	Projected Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care	94,291,123	66.8
TennCare/Medicaid	14,209,583	10.1
Commercial/Other Managed Care	27,901,588	19.7
Self-Pay	269,303	0.2
Worker's Comp	3,756,800	2.7
Charity Care	701,615	0.5
Total	141,130,012	100

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:

Historically, between 50% and 55% of the applicant's LTACH patients originate from Regional One, the applicant's host hospital. Regularly, all other patients originate from other hospitals with no other hospital providing anywhere close to 25% of the applicant's patients. Therefore, the applicant estimates that 55% of their future patients would originate from their host hospital, Regional One. The applicant has a transfer agreement with Regional One Health, as they are both owned by the Shelby County Health Care Corporation.

Historical Inpatient Admissions

Admission Source	2014 Admissions	% Total	2015 Admissions	% Total	2016 Admissions	% Total
Reg One	34	54%	88	49%	102	53%
Other Hosp	29	46%	93	51%	94	47%
Total	63	100%	181	100%	196	100%

Source: 2014 – 2016 Joint Annual Report for Hospitals

Applicant Projected Inpatient Admissions

Admission Source	Year 1 Admissions	% Total	Year 2 Admissions	% Total
Reg One	9,243	55%	9,243	55%
Other Hosp	7,562	45%	7,562	45%
Total	16,805	100%	16,805	100%

Note: the applicant included the above chart labeled as Projected Inpatient Admissions in Supplemental 1 of the application. It appears this chart is actually detailing patient days, not admissions.

The applicant does not know exactly when the new beds will open, but is comfortable estimated for Year 1 and Year 2, as opposed to actual calendar or fiscal years.

This project should not have a negative impact on the health care system. First, doing nothing is always an alternative. However, this was disregarded due to the applicant's high utilization rate as well as other factors indicate a need for more LTACH beds. Second, the construction of a new facility was discarded because it would be cost-prohibitive. It was felt that utilizing existing space on campus would be the most cost-efficient manner in which to provide the additional beds, plus

the fastest manner in which to do so. The LTACH Moratorium, which expired in October 2017, prevented the applicant from adding beds in the past.

The addition of twenty-four (24) beds within a physical space layout that provides for more efficient care coordination for the hospital and patients will permit greater access to care for this highly acute patient population. As part of a health care organization that serves as a Level One Trauma Center and Burn Center, Regional One Health has a great need for long term acute services within its post-acute complement. Furthermore, Methodist Hospital closed its 36 bed LTACH recently and now refers their long-term care hospital patients to the applicant. Since the HSDA (or its predecessor, the Health Facilities Commission) originally approved that facility, it follows that the need for the twenty-four (24) beds requested in the application has already been positively addressed. This is especially true since Select Specialty Hospital, another Memphis-based LTACH, has recently voluntarily surrendered its approved CON # for an additional 28 beds. In effect, sixty-four (64) LTACH beds that have already been approved through the CON process have been taken away from the inventory of needed beds in Memphis. If approved, this application will simply replace 24 of those beds. The addition of these twenty-four beds is a first step in providing continuing care for the long term acute care hospital patients in need of such services.

The applicant, through its Owner, has an agreement with UT Medical School to train Physicians and those Physicians rotate through the LTACH. In addition, the applicant has agreements with both the University of Memphis college of Nursing and Union College for training nursing students, and an agreement with Concord Career College for training of Respiratory Therapy students.

If this application is approved, the applicant will eventually have a fifty-four (54) private bed LTACH located in the Turner Tower, and the twenty-four (24) rehab beds will be relocated. The decision has not been reached as to where those beds will be relocated as of yet.

The floor plan for Turner Tower as it currently exists:

Building	Floor Number	Type of Unit	Licensed Beds	Staffed Beds
Turner	4	LTACH	24	21
	3	Rehab	24	24
	2	Rehab/LTACH	6*	0
	G	Burn Unit	14	14
	B	Detention Unit	10	10
Total Beds			78	69

*Note: An application was recently approved to convert these 6 rehab beds to 6 LTACH beds.

The floor plan for Turner Tower, if this application is approved:

Building	Floor Number	Type of Unit	Licensed Beds	Staffed Beds
Turner	4	LTACH	24	21
	3	LTACH	24	24
	2	LTACH	6	0
	G	Burn Unit	14	14
	B	Detention Unit	10	10
Total Beds			78	69

QUALITY MEASURES:

Regional One Health Extended Care Hospital monitors quality standards through its Quality Assessment and Performance Improvement Program as well as through mandatory quality reporting to the State of Tennessee and the Centers for Medicare and Medicaid Services (CMS).
The applicant is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities. Accreditations are not applicable. The applicant is certified in Medicare and Medicaid/TennCare patients are served through various MCO contacts.

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

LONG TERM CARE HOSPITAL BEDS

A. Need

1. The need for long term care hospital (LTH) beds shall be determined by applying the guidelines of (0.5) beds per 10,000 population in the service area of the proposal.

	2018	*2020*	*2018 LTAC Bed Need*	*2020 LTAC Bed Need*	*2018 Current Beds*	*2018 Net Need*	*2020 Net Need*
Shelby County	970,212	981,022	*49*	*49*	*98*	*(49)*	*(49)*

County	*Existing LTACH Beds*	**Needed LTACH Beds*	*+Surplus/-Need*
Shelby	*99*	*50*	*(49)*

The Department of Health, Division of Policy, Planning, and Assessment calculated the LTACH bed need for Shelby County to be a surplus 49 beds.

Shelby County LTACH Facilities:

Facility	Licensed LTACH Bed	2016 LTACH Patient Days	Licensed LTACH Occupancy
Baptist	30	7,041	64.3%
Methodist*	36	4,808	36.6%
Select	39	10,311	73.4%
Regional**	24	7,160	81.7%
Total	**129**	**29,320**	**62.3%**

*Methodist is now closed.
**Also, since Regional Med staffed only 21 beds historically, the 2016 occupancy rate would have been 93.4% of staffed beds.

2. If the project is a bed addition, existing long term care hospital beds must have a minimum average occupancy of 85%.

Facility	***Licensed Beds***	***2013 Patient Days***	***2014 Patient Days***	***2015 Patient Days***	***2016 Patient Days***	***'13-'15 % Change***	***2013 Occupancy***	***2014 Occupancy***	***2015 Occupancy***	***2016 Occupancy***
Baptist	*30*	*9855*	*8499*	*8354*	*7041*	*-15.2%*	*90.0%*	*77.2%*	*76.3%*	*64.3%*
Methodist*	*36*	*11228*	*11752*	*11485*	*4808*	*+2.3%*	*85.4%*	*89.4%*	*87.4%*	*36.6%*
Select Specialty	*39*	*12811*	*13724*	*13388*	*10311*	*+4.5%*	*90.0%*	*96.4%*	*94.0%*	*72.4%*
Regional Med	*24*	*0*	*1711*	*6854*	*7160*	*n/a*	*0.00%*	*19.5%*	*78.2%*	*81.7%*
Total	*129*	*33894*	*35686*	*40081*	*29320*	*18.25%*	*88.4%*	*75.7%*	*85.1%*	*62.3%*

*Methodist Hospital closed its 36-bed LTACH recently and now refers their long term care patients to the applicant.

Not all facilities are at 85% occupancy in the most recent Joint Annual Report. Average total occupancy for 2016 was 62.3%.The applicant reports operating at 84.2% in 2017 based on the number of licensed beds.

3. The population shall be the current year's population, projected two years forward.

The above guideline was used.

4. The primary service area cannot be smaller than the applicant's Community Service Area (CSA). If LTH beds are proposed within an existing hospital, CSAs served by the existing facility can be included along with consideration for populations in adjacent states when the applicant provides documentation (such as admission sources from the Joint Annual Report).

   The 2017 Shelby County population is 964,804, increasing to 975,626 in 2019, an increase of 1.1%. According to the applicant, in 2015, approximately 83% of their patients from Tennessee originated from Shelby County, approximately 53% of all patients originated from Shelby County, approximately 63% of its patients originated from Tennessee and 37% of its patients came from out of state. Of the out of state patients, 57% originated from Mississippi and about 40% from Arkansas.

5. Long-term care hospitals should have a minimum size of 20 beds.

   The applicant is currently licensed for 24 beds.

B. Economic Feasibility

1. The payer costs of a long-term hospital should demonstrate a substantial saving, or the services should provide additional benefit to the patient over the payer cost or over the provision of short-term general acute care alternatives, treating a similar patient mix of acuity.

   LTACHs are a function of CMS. Prior to the creation of LTACHs, hospitals had to care for chronically ill patients. Based on traditional hospital requirements, acute care facilities lost tremendous amounts of funds caring for such individuals. This fact was recognized and a special category of patients (long term acute care hospital patients) and resultant beds were established that received more appropriate reimbursement. This project continues that additional benefit to the patients they serve, all at a substantial savings over more traditional care.

2. The payer costs should be such that the facility will be financially accessible to a wide range of payers as well as to adolescent and adult patients of all ages.

   The above guideline has been met and will continue to be met.

Payer	Admissions	Percent Total
Medicare	137	69.9%
Tenncare/Medicaid	11	5.6%
Commercial	35	17.9%
Self-Pay	2	1.0%
Charity Care	0	0.0%
Other (WC)	11	5.6%
Total	**196**	**100%**

Age Group	*Admissions*	*Percent Total*
0 – 17	*3*	*1.5%*
18 – 44	*56*	*28.6%*
45 – 64	*41*	*20.9%*
65+	*96*	*49.0%*
Total	***196***	***100%***

**The most recent fiscal year of 2016 runs from 7/15/15 to 6/30/16. Also, the records are kept by age groups of "under 15," "15-17," "18-64," "65-74," "75-84," and "85 and older." Therefore, there is some rounding on the lower chart above to arrive at 100%*

3. Provisions will be made so that a minimum of 5% of the patient population using long-term acute care beds will be charity or indigent care.

Fortunately, CMS recognizes the unique nature of these patients and provides LTACH facilities with substantial reimbursement to help cover the substantial costs incurred by the facilities. In effect, CMS tries to reimburse LTACH facilities in order to keep them in business. To that extent, most patients will qualify for some type of reimbursement. The applicant recognizes that some patients may need charitable care, and provisions are made for such patients. The applicant reviewed the number of charity cases performed by other LTACH facilities in the area and saw that their number of charity cases fell in line with the other LTACH facilities.

C. Orderly Development

1. Services offered by the long term care hospital must be appropriate for medically complex patients who require daily physician intervention, 24 hours access per day of professional nursing (requiring approximately 6-8 hours per patient day of nursing and therapeutic services), and on-site support and access to appropriate multi-specialty medical consultants.

Proposed Staffing

Classification	30 Beds	54 Beds (Year 1)
Title	Existing FTE	Projected FTE
RN	53.3	91.3
CNA	10.1	19.9
Patient Care Extern	0.5	0.9
Dir. Respiratory Care	1.0	2.0
Liaison Nurse	2.0	4.0
Lead Respiratory Nurse	1.0	2.2
Occ. Therapist	0.8	1.6
Physical Therapist	0.9	1.8
Speech Pathologist	1.0	1.9
Patient Care Coordinator	3.5	7.4
Respiratory Therapist	10.2	20.1
Medical Assistant	2.0	3.9
Physical Therapy Assistant	1.1	2.2
Respiratory Therapy Tech	1.0	2.0
Patient Serve Clerk	5.5	11.1
a.)Total Direct Care	93.8	172.3
Nurse Clinical Supervisor	1.0	1.0
Chief Nursing Officer	1.0	1.0
Dir. HIM	1.0	1.0
Case Manager	1.1	3.0
HIM Coding Spec	0.1	0.1
Admitting Coor.	1.0	1.0
Pre-Cert.	1.9	1.9
CMS Data Coor.	1.0	1.0
Admn Sec.	0.0	0.0
b. Total Non-Direct	8.1	10.0
c. Total Contractual	0.0	0.0
Total (a+b+c)	101.9	182.3

Patient services should be available as needed for the most appropriate provision of care. These services should include restorative inpatient medical care, hyper alimentation, care of ventilator dependent patients, long term antibiotic therapy, long-term pain control, terminal AIDS care, and management of infectious and pulmonary diseases.

Also, to avoid unnecessary duplication, the project should not include services such as obstetrics, advanced emergency care, and other services which are not operationally pertinent to long term care hospitals.

The above guideline has been met and will continue to be met.

2. The applicant should provide assurance that the facility's patient mix will exhibit an annual average aggregate length of stay greater than 25 days as calculated by the Health Care Finance Administration (HCFA), and will seek licensure only as a hospital.

The above guideline has been met and will continue to be met.

3. In the most recent year, the actual average hours per patient day for rehabilitation were 0.4 hours per patient day. The actual average hours per patient day for nursing hours for the most recent year available were 9.43 hours per patient day. Due to the acuity of the patient population seen at the applicant's host hospital, Regional One Health Extended Care Hospital, the projected nursing staff hours will be 9.48 hours per patient day. The projected therapy staffing will be 0.4 hours per patient day consistent with the actual number in the most recent year. Combined nursing and therapy staffing hours per patient day will be 9.88. The applicant will continue to focus on nursing and therapeutic care for patients with a projected caseload of no more than three hours per day of rehabilitation.

Staff	FTE	Production Hrs/Week	Hrs/Week	Weeks/Year	Total Hrs	Patient Days	Hrs/Patient Day
Nursing	85.1	36	3,064	52	159,307	16,805	9.48
Rehab	3.6	36	129	52	6,722	16,805	0.40
Total							**9.88**

The above guideline has been met and will continue to be met.

4. Because of the very limited statewide need for long term hospital beds, and their high overall acuity of care, these beds should be allocated only to community service areas and be either inside or in close proximity to tertiary referral hospitals, to enhance physical accessibility to the largest concentration of services, patients, and medical specialists.

The above guideline has been met and will continue to be met.

5. In order to insure that the beds and the facility will be used for the purpose certified, any certificate of need for a long term care hospital should be conditioned on the institution being certified by the Health Care Financing Administration as a long term care hospital, and qualifying as PPS-exempt under applicable federal guidelines. If such certification is received prior to the expiration date of the certificate of need, as provided in Tennessee Code Annotated (TCA), Section 68-11-108(c), the certificate of need shall expire, and become null and void.

The applicant accepts this condition.